

Personality

In this issue

Guest Interview: Jonathon Shedler

DSM-V

Identity Attachment Culture

Interpersonal patterns (CCRT)

PD Outcomes

A neurobiological theory (RST)

Personality of the Psychotherapist

Ethics of Assessment

EDITORIAL

Kaye Horley, PhD
Editor

Let me think. Was I the same when I got up this morning? I almost think I can remember feeling a little different. But if I'm not the same, the next question is 'Who in the world am I? Ah, that's the great puzzle!'

"Who am I?" is the perennial question we all ask. What is it that defines us and makes us unique? Conceptualising the complexities of personality is inherently difficult and controversial, yet vital for clinical practice. In this edition of the ACPARIAN leaders in the field provide differing, considered perspectives.

Jonathon Shedler, interviewed by Judy Hyde, emphasises the importance of clinicians understanding and responding to a person's underlying personality dynamics in treating a symptom such as depression, and discusses the reasoning behind his involvement in a new taxonomy of personality syndromes.

DSM-V is an attempt to overcome many of the inherent problems in the current classification of PDs. An overview of the proposed changes specifying the new general definition involving impairment of the self and interpersonal functioning is provided by Carol Hulbert who provides firsthand experience of the complexities of its application. This new focus provides the impetus for Simon Boag's paper in which he explores the meaning of self and identity within the framework of this new conceptualisation. The proposed new definition is also addressed by Nicholas Tiliopolous and Yixin Jiang, in a critical review of research assessing the evidence for attachment constructs underlying personality disturbances. The fragility of one's identity is personified in a client's revealing exposure of her search for identity and its constraint upon her relationships.

Providing a much needed explanatory framework for therapists in attaining an understanding of an individual's self and interpersonal underlying conflicts and patterns is the Core Conflictual Relationship Theme Model, expounded by Brin Grenyer. There is particular need for awareness by therapists that those with personality disorders experience high levels of psychological distress as a result of social dysfunction. The relationship between PDs and culture is a relatively unexplored subject. Yet it can be argued that our cultural heritage helps in defining who we are. McLytton Clever places emphasis upon the need for cultural awareness by clinicians when assessing an individual's behaviour, particularly in light of a considered DSM Western orientation. The beginnings, course and outcome of PDs, and the associated gaps in our knowledge, is highlighted by

Conan Dugan in his review of the literature. Many have ongoing difficulties in interpersonal relationships and sense of self.

What of the neuroscience underlying PDs? The Reinforcement Sensitivity Theory is proposed by Phillip Corr and Giles Burch as a major explanatory model for individual differences. In a later paper, Giles Burch points out the inherent ethical difficulties in psychometric assessment of personality and its dimensions, including limitations of the clinician.

What is it that draws people towards a particular profession such as clinical psychology? We can all come up with any number of altruistic reasons, but perhaps only our unconscious really knows what may have lead us into this area. Read Judy Hyde's thought-provoking paper to engage in some self-analysis.

So are we normal or not? It can be hard to tell if we follow the DSMs. But don't worry if you have a Histrionic Personality Disorder, when the new DSM V classification appears your PD will disappear.

Finally, we are very sorry to be losing our meticulous copyeditor, Bronwyn Williams who has helped define the ACPARIAN. Her contribution has been much appreciated.

¹Carroll, L. (1982). *Alice's Adventures in Wonderland*. London: Chancellor Press. (Original work published 1865)

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FROM THE PRESIDENT

*Judy Hyde, PhD
ACPA President*

This has again been a very busy quarter for ACPA. Following the visit to ACPA and the Psychology Clinic at the University of Sydney by the Minister for Health, the Hon Tanya Plibersek, we were visited by Shadow Minister for Mental Health, Senator Fierravanti-Wells, the Director for Health Workforce, Australia, Mr Ian Crittenden, and Bethany French, and a team from the Department of Human Services, Ms Lenore Simpson, National Manager, Business and Public Compliance Branch, Ms Toni Sanders, Director, Compliance Strategy – Health Support Section, Mr Gerry Manteit, Business Manager, Health Professional Information and Education Services, and Ms Patricia Carnevale. The Psychology Clinic at the University has proven a valuable means of showcasing the training of clinical psychologists, particularly due to the standing of the University of Sydney itself, and the fact that for ten years the University has offered only a Doctor of Clinical Psychology program.

The clinic is housed in an old, but newly renovated building and boasts state of the art technology. An impressive system of viewing sessions from supervisors' offices is demonstrated to visitors whereby all 12 clinic consulting rooms are able to be seen at once on the screen and a single room can be selected for full screen view. Each room can be recorded with the press of a button or viewed live. The clinic and adjacent academic area is a very professional light well furnished space, of which we are justifiably very proud.

The Dean of Science, Professor Trevor Hambley, and Head of School, Professor Sally Andrews, with Professor Stephen Touyz, attended the visit by Minister Plibersek. It was delightful to hear the Dean explain to the Minister that the University continued to provide training and invest heavily in the clinical psychology program, despite the program running at a loss, because of value of clinical psychologists to the

public, their role in contributing to the research literature for the University, and the importance of clinical psychology as a profession. Minister Plibersek took away a bundle of brochures from the clinic and from ACPA.

At the meeting with representatives from the Department of Human Services, the ACPA Medicare Taskforce was able to present the document prepared by Leanne Clarke on behalf of and with the assistance of members about the range of concerns ACPA members dealing with Medicare have. This document has been taken seriously and the issues followed up by the Department. Some of the difficulties raised will be referred, with the support of the Department of Human Services, to the Department of Health and Aging, where they relate more to their area of authority.

During this period, as President of ACPA, I was approached to respond to an audit of the independence of the Australian Psychology Accreditation Council (APAC) and was able to raise a number of serious concerns about the conflicts of interest and dominance of the Australian Psychological Society (APS) on the Board of APAC. ACPA was also invited to send a representative to the APAC preliminary consultation of major stakeholder's meeting in Sydney, at which the review of standards for the profession of psychology was commenced. Alice Shires, from the University of New South Wales, represented ACPA at this preliminary meeting. A submission to APAC to address issues raised at this meeting is being developed by ACPA. Further widespread consultation is still to take place regarding the standards to be set for the profession.

Over the past quarter ACPA has launched its Mentoring program for new members of the profession. The Mentoring Team, led by Leanne Clarke and Chris Basten, has done a magnificent job in developing and operating this program. On behalf of the members, particularly our junior colleagues, we thank you for this important initiative.

We are soon to launch a new Ethics blog that will enable discussion of ethical issues by members. This is a wonderful

initiative developed by the Ethics Committee, led by Sonia Smuts.

ACPA has grown beyond the capacity for those managing the administration to cope with the demands of new memberships and renewals; hence we have a new website about to be launched. This will enable online applications and renewals as well as greater utility and better accessibility for members. Meanwhile, the heart of ACPA, its listserve, beats strongly and more professionally than ever.

In terms of professional development, ACPA has presented a day with internationally renowned, Jonathan Shedler. This was a huge success with a psychodynamic model of working being demonstrated that fully utilises the therapeutic relationship to address themes in the individual's relating that underlie their difficulties. Sam May and Alice Shires are very much valued and appreciated for undertaking the demanding task of organising the day; and the two members who presented cases, Louise Hird and Sonia Wechsler, were greatly enjoyed for the open and thoughtful manner in which they presented their cases for supervision by Dr Shedler.

In this issue of the ACPARIAN you will find an interview held with Dr Shedler that I had the privilege of undertaking. Like other international colleagues, he is a strong supporter of ACPA and its mission, and is extremely interested in the politics of psychology in Australia at present.

Our most recent initiative has been the proud announcement of the Malcolm Macmillan Prize for student members. This prize is in honour and celebration of our colleague, Professor Macmillan, from the University of Melbourne. Mac has worked tirelessly throughout a long and illustrious career to promote psychology and high standards. As a founding member, past president and fellow of the Australian Psychological Society (APS), Mac terminated his membership publically as one of the 'Melbourne Six', all leading academics at the University of Melbourne, who, with national publicity, left the APS in protest of the lowering of standards for entry to the College of Clinical Psychologists of the APS. We are proud to have him as a founding singular emeritus member of ACPA.

A policy has been developed for advertising in the ACPARIAN by McLytton Clever with support from the Editorial Committee. This will be placed on the new website in due course, along with a manual of all the policies developed over the past 2 years or so. What a journey it has been!

Throughout this edition you will once again see the wonderful work of the ACPA Editorial team. The magazine has reached many within the profession, but also in related professions and has been consistently acclaimed for its high quality and utility for clinicians. We will continue to make the latest edition freely available on the website.



ACPA BOARD REPORT

*Caroline Hunt, PhD
ACPA Vice-President*

Many of the Board's activities since the last issue of the ACPARIAN have been covered in the President's Address, and so I will just cover a few administrative matters in this issue.

First, we are very pleased to welcome ACPA's new Administrative Assistant, Jay Natarajan, who will be helping us with Board support, membership processes and accounting activities. Jay is a very welcome member to our team. Along with the new on-line membership database that is being developed, this appointment will see ACPA's administration become more streamlined and efficient in the months to come.

Second, the Board has recently agreed to undertake a review of all company policies, and will be asking members for feedback before ratifying all policies. We will endeavour to undertake this process annually, which will allow all members to comment on all existing and newly developed policies.

Last, I wanted to flag that there will be important resolutions regarding ACPA's Constitution at the upcoming AGM in Fremantle in October. As members will know, we are operating under our original constitution, and there are a number of sections that need to be updated. For example, our current constitution still requires a quorum of 20% of members which, with our growing membership, will become more and more difficult to meet. Again I shall be calling for proxies from members not attending our AGM so that we meet the quorum requirements and run the AGM. One resolution proposed will be to change this requirement.



FEATURE ARTICLE

AN INTERVIEW WITH JONATHON SHEDLER

Interviewed by Judy Hyde

*Jonathan Shedler, PhD is a leading expert on personality and psychotherapy. His landmark article, *The Efficacy of Psychodynamic Psychotherapy* (American Psychologist, 2010) won international acclaim for establishing psychodynamic therapy as an evidence-based therapy. His research and writing on personality patterns and disorders is transforming contemporary views of personality and its treatment.*

Dr. Shedler is co-author of the Shedler-Westen Assessment Procedure (SWAP) for personality diagnosis and clinical case formulation. He is Associate Professor of Psychiatry at the University of Colorado School of Medicine, Director of Psychology at the University of Colorado Hospital Outpatient Psychiatry Service, and a faculty member at the Denver Psychoanalytic Institute. He is also a certified ski instructor.

Welcome to Australia, Jonathan and thank you for the wonderful training day you offered to ACPA and members of the psychotherapy community on 20th May. The feedback from those who participated on the day has been outstanding. We all learned and developed our understanding of the central role of personality in treatment from your insightful and knowledgeable presentations. Thank you too for agreeing to this interview for the ACPARIAN.

1. Can you tell me why we need to diagnose personality?

Clinicians need to understand personality functioning in order to help people in meaningful ways. In general, the problems that bring people to therapy are woven into the fabric of their lives and rooted in patterns of thinking, feeling, motivation, coping, and relating to others— in other words, personality. Any approach to therapy that is intended to be more than a psychological Band-Aid must address the personality patterns that give rise to the person's difficulties. An understanding of personality is a roadmap for effective therapy.

To offer an example, the most common symptom that brings people to therapy is depression. DSM-IV encourages us to view depression as a disease or disorder in its own right, but it is more helpful to think of depression as the psychological equivalent of fever. Fever is a non-specific response to an enormous range of underlying conditions. Depression is a non-specific psychological response to underlying psychological difficulties which are generally rooted in personality. Effective clinicians understand and treat *personality*.

Different personality styles constitute different pathways to depression. To give a few examples, patients with narcissistic personalities are vulnerable to depression because there is a chronic mismatch between their grandiose expectations and what reality actually affords. They feel constantly wounded, injured, or deprived. Patients with paranoid personalities are vulnerable to depression because they feel themselves to be surrounded by enemies. They experience the world as emotionally cold, desolate, and dangerous. Avoidant personality is another pathway to depression because avoidant individuals squelch their needs and desires and cut themselves off from the things that bring people satisfaction and fulfillment. I could go on. All of these conditions may look the like "depression" from the "outside" but they are not the same and cannot be treated the same way. A clinician who attempts to treat "depression" without understanding the personality dynamics that give rise to it will not be helpful, or will be helpful only in a superficial and temporary way.

2. Jonathan, can you say something about the syndromal or dimensional characteristics of personality as opposed to the categorical typology currently promoted by DSM IV?

Most clinicians understand that DSM-IV is something of a polite fiction. Emotional suffering doesn't come pre-packaged in neatly arranged categories, and all psychological syndromes really exist on continua. Categorical diagnosis is especially problematic for personality. Every human being has a personality style. When a personality style is so inflexible and rigid that the person has persistent problems in living, we may call it a *disorder*. But there is no hard-and-fast dividing line between a personality style and personality disorder. The term *disorder* is just a linguistic convenience.

For example, narcissistic personality exists on a continuum from healthy through profoundly impaired, as we have shown in our research. It is just silly to draw a line and say that someone who meets five out of nine DSM-IV diagnostic criteria “has” narcissistic personality disorder and someone who meets four criteria is healthy. The criteria themselves also fall on continua. Lack of empathy is a diagnostic criterion for narcissistic personality disorder, but just how much or how little empathy constitutes “lack of empathy?”

I think the attempt to turn personality into a categorical typology of present/absent “disorders” was primarily an effort to shoe-horn personality into a medical disease model that doesn’t fit. Personalities are not “diseases” that you catch, like influenza. Personality is how we live our lives—our way of being.

3. With your colleagues you have developed a taxonomy of personality types founded on decades of research. Can you say how you went about this enormous task?

The concept is simple, although the execution took some doing. First, we needed to develop a way for clinicians to provide richly detailed, psychologically comprehensive descriptions of their patients’ personalities. Drew Westen and I developed our personality assessment instrument, the SWAP (Shedler-Westen Assessment Procedure), for this purpose. A guiding principal was that the SWAP item set should encompass the full spectrum of psychological phenomena that clinicians consider important, that have been described repeatedly in the clinical literature. To my knowledge, no one had done this before. Generally, psychology researchers select a small set of concepts or variables to study *a priori*, without regard for over a hundred years of accumulated clinical knowledge. This step alone—developing a truly clinically meaningful item set—took over 12 years.

The next step was to use the SWAP instrument to collect detailed psychological descriptions of patients from large, clinically representative samples. Our most recent research is based on a sample of N=1201 patients. We set aside all theory and preconception and used statistical methods to identify naturally occurring diagnostic groupings—that is, groupings of patients who were psychologically similar to one another, and distinct from patients in other groupings. The intent was to “carve nature at the joints” as accurately as available methods permit.

Once we identified naturally occurring personality groupings or syndromes, we created a diagnostic prototype to describe each syndrome. A diagnostic prototype is a description, in paragraph form, of the essential features of a personality syndrome. Prototypes are the basis for the diagnostic system we have proposed for DSM-5 (Westen, Shedler, Bradley & DeFife, 2012).

4. Clinicians work from different models, each with their own way of thinking and talking about how the patient presents. What makes you think that this taxonomy of personality will be more useful for clinicians than describing observable behaviour, as does the current DSM?

That’s a good question. First of all, DSM-IV doesn’t work for personality. Its diagnostic descriptions (categories and criteria) lack fidelity to the personality syndromes clinicians see in real-world practice. DSM-IV personality diagnosis does not help clinicians better understand their patients or treat them more effectively, which is the primary purpose of diagnosis. Perhaps this is why clinicians ignore Axis II most of the time. In clinical chart records today, the most common entry after Axis II is “deferred.” If clinical practitioners found Axis II clinically useful, they would use it. Clinicians have already voted with their feet, so to speak.

One reason DSM-IV is not more helpful is because personality is *not* primarily about observable behaviours — it is about the psychological processes that underlie behaviour. For example, stealing is a behaviour, but stealing cannot tell us whether someone has a psychopathic personality style. There is a world of difference between someone who steals out of desperation, perhaps to feed a hungry child, and feels deeply ashamed about it, and someone who steals for the thrill of getting away with it. It is not the behaviour but its *meaning* that is relevant. I think psychologically sophisticated people understand this.

Psychopathic personality is defined by *internal psychological processes* that cannot be observed directly, but that knowledgeable clinicians can infer reliably—for example, pleasure in exploiting others, lack of remorse, and lack of empathy for pain they cause others. These are not behaviours; they are internal processes and experiences. You cannot describe personality syndromes in terms of behaviour alone—you have to get “inside” the person and understand their inner experience. DSM-IV misses internal psychological processes that are essential to understanding personality syndromes. As a result, it is not especially clinically helpful.

As for clinicians working from different models, we went to lengths to make sure that the SWAP items, and the diagnostic prototypes we created from them, were free of jargon and useful to clinicians of all theoretical orientations. We worked to describe complex psychological phenomenon in plain English. For example, the SWAP does not contain an item that uses the term “projection” (which turns out to be central to understanding paranoid personality). The SWAP item that addresses this phenomenon reads, “Tends to see own unacceptable feelings or impulses in other people instead of in him/herself.” This is plain English, and the item can be scored by clinicians of any orientation. The statement is either applicable to a given patient or it is not. As another example, consider the concept of “splitting” (or “dichotomous thinking”) in patients with borderline personality. This is a

concept that trainees often struggle to understand. The SWAP addresses splitting with the following item: “When upset, has trouble perceiving both positive and negative qualities in the same person at the same time (e.g., may see others in black or white terms, shift suddenly from seeing someone as caring to seeing him/her as malevolent and intentionally hurtful, etc.).” Clinicians of any theoretical orientation can understand this language.

It is ultimately an empirical question whether clinicians find the diagnostic approach helpful. Over 80% of clinicians who used the SWAP-II (the latest edition of the SWAP) to describe a patient agreed or strongly agreed with the statement, “The SWAP-II allowed me to express the things I consider important about my patient’s personality.” A study conducted by an independent research group led by Robert Spitzer¹ asked clinicians to compare and rate the utility of five alternative approaches to personality diagnosis (including the current DSM-IV system, the Five Factor Model, and other diagnostic systems that have been proposed for future editions of the DSM). Clinicians preferred the SWAP approach hands down (Spitzer et al., 2008).

5. Can you tell me how the prototype matching approach to diagnosis that operationalises your system of classification of personality disorders may assist clinicians in guiding treatment?

Every diagnostic prototype is not only a description, but also a concise *clinical case formulation* with direct treatment implications. For example, DSM-IV tells us that patients with paranoid personality are suspicious, which is true. The SWAP diagnostic prototype also tells us *why* they are suspicious. What we learned empirically through SWAP research confirmed some long-held clinical theories about the causes of paranoid thinking. People with paranoid personality are deeply angry and hostile. But instead of recognizing their own anger, they misattribute it to others and see *other* people as hostile. So we know that effective treatment must help the patient recognise and develop more adaptive ways of managing anger. The diagnostic prototype also makes clear that thinking in patients with paranoid personality can become impaired and distorted — so the clinician will need to help the patient with reality testing, paying careful attention to his thought process and reasoning. This is very direct clinical guidance.

6. Can you tell me how the SWAP works as a measure of personality syndromes and dysfunction? That is, how does a clinician use it, and how does it provide results?

Clinicians can download SWAP software from www.SWAPassessment.org. The instrument consists of 200 items or personality-descriptive statements. Each item may

describe a given patient well, somewhat, or not at all. Using the software, the clinician sorts the statements into eight categories, from not descriptive of the patient (assigned a value of 0) to most descriptive (assigned a value of 7). When the clinician finishes entering item scores, the SWAP software computes and graphs 37 diagnostic scales.

The built-in scoring algorithms optimally combine and weight the information the clinician has provided in order to generate diagnostic scales with maximum reliability, validity, and predictive accuracy. The diagnostic scales are organised into three score profiles (resembling MMPI profiles). The first score profile contains scores for DSM-IV personality disorder diagnoses. This for “backward compatibility” with DSM-IV, since most clinicians are still required to make DSM-IV diagnoses. The second profile contains scores for the new diagnostic prototypes that we’ve discussed here, and this is really the heart of the test. There is a third score profile that provides scores for trait dimensions, that hone in on specific areas of functioning that are of clinical interest. Also, the SWAP assesses psychological health as well as pathology. It includes a psychological health index that measures adaptive psychological capacities and resources. This scale is clinically valuable because it tells clinicians what personality strengths they will be able to draw on as therapy proceeds. Good therapy works with patients’ strengths, not just their limitations.

7. Given that the SWAP relies on considerable input from someone who knows the individual well, how do you see this working for researchers?

It works well for researchers. A knowledgeable clinician can score the SWAP after a minimum of six hours of clinical contact with a patient. For research use (and for other situations where the patient is not in therapy, like forensic evaluation), my colleague Drew Westen developed an interview, the Clinical Diagnostic Interview (CDI), that takes about 2 ½ hours to administer. It is a systematic version of the kind of interviewing a skilled clinician would engage in during the initial hours of patient contact. In a research context, an assessor can score the SWAP reliably and validly based on the CDI interview.

8. Students often ask how supervisors ‘know’ what personality dynamics a patient is displaying in the room. How would you respond to this question?

I think this kind of expertise rests on pattern recognition. Through study and experience, expert clinicians learn to recognise the range of personality patterns that we frequently encounter in clinical practice (and in life — we all have personality styles, not just our patients). Novices may require a great deal of information before they recognise a pattern, and may need a supervisor’s help to connect the dots and help them see it. An experienced clinician may be able to recognise a pattern quickly, with less information. It’s like recognizing a

¹The editor of the DSM-III and the architect of the DSM diagnostic system we know today.

face. If you know someone well — say a close friend or family member — then you can recognise him from a blurry photo. You can recognise him from a photo where you can see only part of the person's face, like just an eye, or perhaps the person's lips and chin. Once you know what a person looks like, you know.

Another analogy is how a wine expert comes to know and recognise different wines. If you give me a glass of wine, I will tell you that it is red and whether I like it or not. But a person who knows wines will tell you whether it is a Merlot, or a Cabernet, or a Bordeaux, and he will get it right. If he is a real expert, a sommelier, he may be able to tell you what region the wine is from, and its vintage, and whether it was a good year. From a novice's perspective it can seem like magic, or seem like he's just making it up, because the novice can't tell the difference. But the sommelier is not making it up, he knows. How does he know? Study and experience. He's learned to recognise the patterns of taste and smell and colour that identify a wine, and he's learned what to pay attention to. We also have to learn what to pay attention to.

Jonathan, it has been a great privilege to interview you for the ACPARIAN and to have another opportunity to have you elucidate some of the core concepts involved in the assessment of personality disorders. I hope you enjoy the rest of your stay in Australia and return soon to share with us more of this fascinating and central aspect of the work of the clinician.

The SWAP instrument for personality diagnosis and case formulation can be downloaded from www.SWAPassessment.org.

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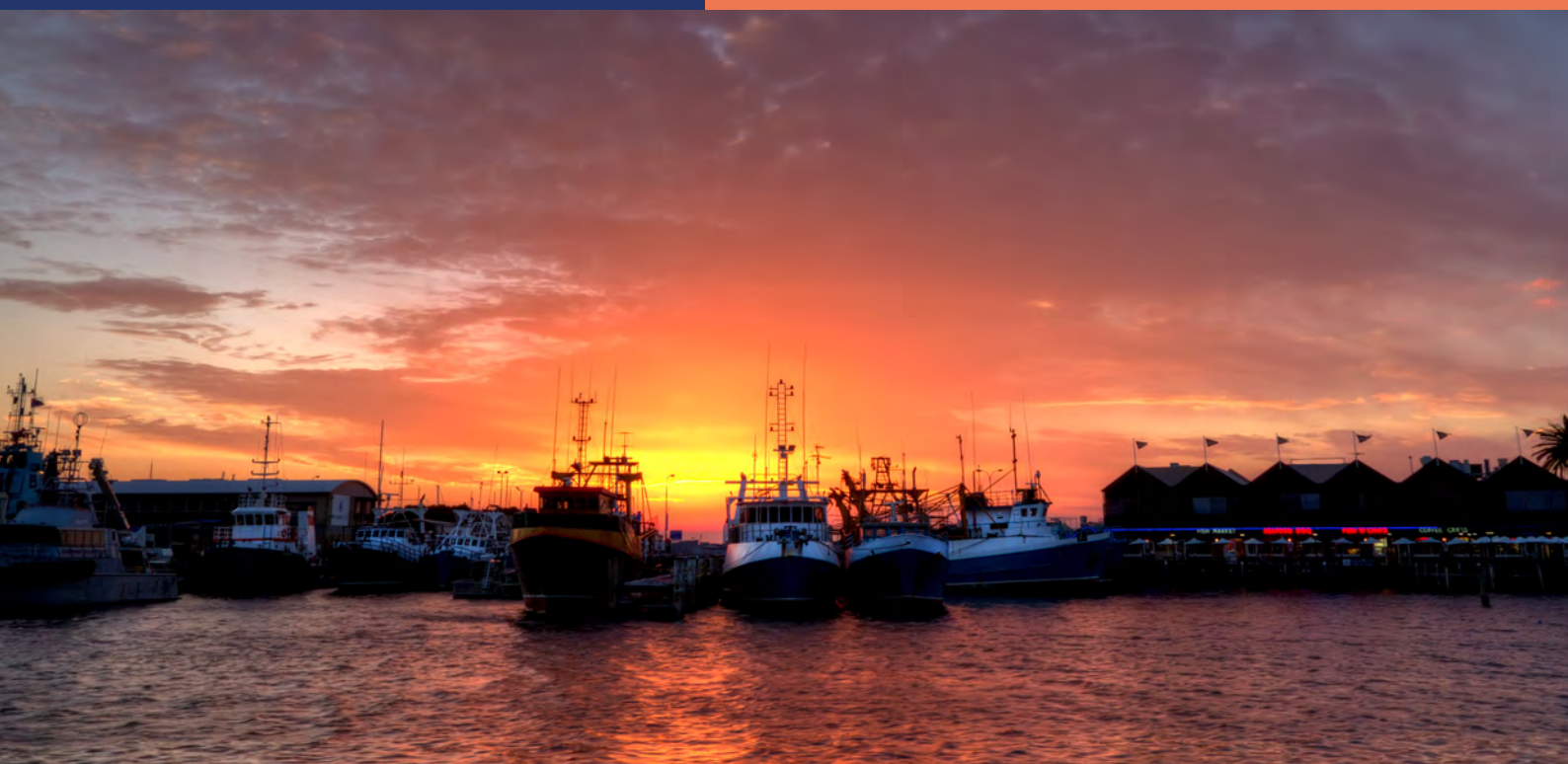
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CLASSIFICATION OF PERSONALITY DISORDER IN DSM-V

Carol Hulbert, PhD

A/Prof. Carol Hulbert is a registered clinical psychologist and clinical researcher with extensive past experience in mental health services. Her current position in the School of Psychological Sciences, University of Melbourne, is Director of the postgraduate Clinical Psychology Program. She has previously worked as a clinician, manager and regional senior psychologist in public mental health. Her program development experience included involvement in the setting up of EPPIC and the Spectrum Personality Disorder Service of Victoria. Areas of research interest include social cognition and interpersonal functioning in borderline personality disorder and psychological treatment of personality disorder.

The upcoming publication of DSM-V has provided impetus and focus to the ongoing debate regarding the definition and appropriate classificatory system for the personality disorders. Empirically-informed models of classification of personality and personality disorder are central to sound clinical practice in this complex and often challenging clinical domain. Robust research findings confirming the inherently dimensional nature of personality and personality disorder highlighted the need for a major revision of current categorically-based nosologies. This challenge has been enthusiastically taken up by the DSM-V Personality Disorders Task Force under the leadership of Professor Andrew Skodol. The radical changes proposed, including the implementation of dimensionally-based assessment of personality disorder and a reduction in the number of personality disorder diagnoses, are described below. Initially, however, theoretical commentary and key empirical findings bearing on the classification of personality disorder are outlined.

Definition of Personality and Personality Disorder

This paper provides an opportunity to acknowledge the seminal work of Theodore Millon. Over many decades, his theoretical contributions have provided clarity and direction, as regards the definition, classification and treatment of personality disorder. With his emphatic statement that personality disorder can be assessed, but not diagnosed, Millon foreshadowed important aspects to the proposed model for DSM-V (Millon & Davis, 1996). Liking personality to the immune system (rather than a disease or disorder), Millon argued that the primary purpose of personality is the organisation and integration of experience, including patterns of thinking, feeling and behaviours, so as to allow consistency and predictability in functioning across life domains. Hence, he defined personality dysfunction in terms of tenuous

stability in the face of life stress, functional inflexibility (that is, the continued reliance on rigidly applied patterns of behaviour in the face of life situations offering opportunities for adaptation and growth), and self-defeating patterns of behaviour.

Subsequent research has confirmed that personality is inherently dimensional and that the same factors inform the development of normal and disordered personalities (e.g., Livesley, 2008). There is now widespread agreement that both normal and disordered personality are underpinned by a set of dimensional traits that are genetically-based, that there is no identifiable delineation between normal and disordered personality functioning and personality disorder is best defined in terms of very high or low levels of the core traits (Skodal et al., 2002; Widiger, Livesley, & Clark, 2009). Research based on the prominent Five Factor Model identifies traits of neuroticism, extraversion, conscientiousness, agreeableness, and openness to experience as stable over time and reliably identifiable across national and cultural groups (Costa & Widiger, 2002; McCrae & Costa, 1984). Also, research undertaken by Livesley et al (1996) identified four higher order factors (affective instability, inhibition, compulsivity, and dissociality, respectively) and 14 lower order factors, in the process providing strong evidence that the same genotypic and phenotypic structure underpins normal and disordered personality.

Towards DSM-V

The inclusion in the DSM-III (American Psychiatric Association, 1980) of operational criteria for 11 diagnosable personality disorders, set out on a separate axis, represented a major advance for the field. This innovation encouraged clinicians to consider assessment of personality disorder alongside of common psychological disorders, such as anxiety and mood disorders, at the same time heralding a dramatic increase in research. The personality disorders were organised on Axis II as three clusters labelled as 'odd' or 'eccentric' (paranoid, schizoid and schizotypal personality disorders), 'dramatic', 'emotional', or 'erratic' (histrionic, narcissistic, antisocial and borderline personality disorders), and 'anxious' or 'fearful' (avoidant, dependent, compulsive and passive-aggressive personality disorders). With a few exceptions, these diagnostic categories arranged in the same three clusters have remained consistent over subsequent DSM revisions, including DSM-III-R (American Psychiatric Association, 1987) and DSM-IV (American Psychiatric Association, 2000). A further significant advance was the move from monothetic (that is, all listed criteria are required to make the diagnosis) to polythetic categories (that is, a specified minimum number of equally weighted criteria are required to make the diagnosis).

The publication of DSM-III and its successors has contributed to the field in a range of ways. Clinicians have been made more aware of the possibility of personality disorder predisposing individuals to develop certain disorder,

co-occurring with Axis 1 disorder, and as complicating the presentation and/or treatment of other disorders. The resultant research led to the development of new measures of personality disorder and empirically validated treatments, particularly for borderline personality (Hulbert, Jackson, & Jovev, 2011). Other significant research foci have included large scale epidemiological studies and investigations of the relationship between Axis 1 and II disorders. Nonetheless, significant criticisms of the DSM remain: these include the lack of empirical validation of the three cluster structure, the limited reliability of personality disorder diagnosis and criteria, the problem of diagnostic overlap (leading to some individuals receiving multiple Axis II diagnoses), and the inevitable loss of clinical relevant information when categories are used to assess trait-based phenomena (Hulbert & Jackson, 2011).

The Proposed Model for DSM-V

Based on extensive reviews of the literature, the model put forward by the DSM-V Personality Disorders Task Force proposes radical changes to the classification and assessment of personality disorder, including dimensional assessment of personality disorder, a reduction in the number of personality disorder types (to 5 types), and changes to the general diagnostic criteria. In the Task Force's 2010 online report the revised General Diagnostic Criteria for Personality Disorder includes a definition of personality disorder as "the failure to develop a sense of self identity and the capacity for interpersonal functioning that are adaptive in the context of the individual's cultural norms and expectations". The adaptive failure associated with self-identify impairment and interpersonal dysfunction must have an onset in adolescence, be associated with extreme levels of one or more personality traits stable across time and consistent across situations. The adaptive failure must not be solely a manifestation or consequence of another mental disorder or due to the direct physiological effects of a substance or general medical condition. Also, the adaptive failure cannot be better understood as a norm within an individual's culture.

The model for DSM-V sets out three steps for the assessment of personality disorder. Initially, clinicians are asked to provide an overall rating of severity of dysfunction (from 0=no impairment to 5=extreme impairment) for the same two aspects of personality (that is, self-identity and interpersonal functioning). Functioning in the domain of self is assessed in terms of identity integration, integrity of self-concept and self-directedness. Interpersonal functioning is rated in terms of empathy, intimacy and cooperativeness, and complexity and integration of representations of others.

The second step requires the clinician to rate individuals against prototypic descriptions for five personality disorder types (schizotypal, borderline, antisocial, obsessive-compulsive, and avoidant) on a 5-point scale (5=very good match to 1=no match). For the third step, six broad traits and 37 lower order facets are rated using a 4-point scale (0=very

little or not at all descriptive to 3=extremely descriptive). The six broad traits and the 37 facets are presented in Table 1. Explicitly acknowledging the importance of dimensionally-based assessments, the Task Force recommends that these traits and facets be utilised to assess personality dysfunction in individuals not meeting criteria of one of the five types. It is worth noting that the evidence base for the six traits nominated for inclusion comes largely from research undertaken using similar, though differently labelled, traits from McCrae and Costa's (1984) Five Factor Model, Livesley et al's (1998) 18-Factor model, and Cloninger's (1994) seven-factor model.

Not surprisingly perhaps, the reduction in the number of personality disorder types has sparked some controversy. The rationale for the selection of personality disorder types was that there was evidence of the type being prototypic, that is, a unique entity (e.g., Westen, Shedler, & Bradley, 2006), so as to avoid the problems of diagnostic overlap. Thus, one aim of the revised model is to do away with the need for the widely utilised Personality Disorder Not Otherwise Specified category. A further factor appears to have been the limited literature for four of the deleted types (i.e., schizoid, paranoid, histrionic, and dependent). However, the conclusion that a lack of research for these four types is evidence of the absence of prototypicality is questionable. The stronger research literature and sustained support for the inclusion of the narcissistic type seems to have been taken note of by the Task Force, with the indications at this stage being that this type will be included in DSM-V.

The main criticisms of the proposed model are: (1) the absence of psychometric data supporting its reliability and validity; and (2) concern about how this complex model might be applied in clinical practice. I had firsthand experience of the challenge of applying the model as a participant in a workshop lead by Professor Skodol and held as part of the XIth International Society for the Study of Personality Disorder Congress in New York in 2009. The full model proved complex and time consuming to apply to clinical case studies, raising the possibility that clinicians might opt to utilise part/s of the model, in the process perhaps further comprising the validity of the model. In summary, the proposed model has a strong evidence base and represents a major innovation for the field. The priority now is for the implementation of rigorous field trials to establish the reliability, validity and clinical utility of the model.

Table1: Proposed DSM-V personality disorder types, traits and facets

Personality Disorder Type	Traits and facets
Antisocial/ Psychopathic	<p>Antagonism: Callousness, Aggression, Manipulation, Hostility, Deceitfulness, Narcissism</p> <p>Disinhibition: Irresponsibility, Recklessness, Impulsivity</p>
Borderline	<p>Negative Emotionality: Emotional Liability, Self-harm, Separation Insecurity, Anxiousness, Low Self-esteem, Depressivity,</p> <p>Antagonism: Hostility, Aggression</p> <p>Schizotypy: Dissociation Proneness</p>
Avoidant	<p>Negative Emotionality: Anxiousness, Separation Insecurity, Pessimism, Low Self-esteem, Guilt/Shame, Intimacy Avoidance</p> <p>Introversion: Social Withdrawal, Restricted Affectivity, Anhedonia, Social Detachment</p> <p>Compulsivity: Risk Aversion</p>
Obsessive- Compulsive	<p>Compulsivity: Perfectionism, Rigidity, Orderliness, Perseveration,</p> <p>Negative Emotionality: Anxiousness, Pessimism, Guilt/Shame</p> <p>Introversion: Restricted Affectivity</p> <p>Antagonism: Oppositionality</p>
Schizotypal	<p>Schizotypy: Eccentricity, Cognitive Dysregulation, Universal Perceptions, Unusual Beliefs</p> <p>Introversion: Social Withdrawal, Restricted Affectivity, Intimacy Avoidance</p> <p>Negative Emotionality: Suspiciousness, Anxiousness</p>

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IDENTITY AND DISORDERS OF THE SELF

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While the DSM-IV TR conceptualises personality disorders in terms of culturally deviant, pervasive, and inflexible patterns of thinking, feeling, acting (i.e., traits), the proposed DSM V promises a renewed focus on self and identity for conceptualising impairments in personality functioning. More specifically, an essential criterion for personality disorders in the DSM V proposal concerns significant impairments in *self*, which encompasses both 'identity' and 'self-direction'. Accordingly, there are important theoretical questions that arise both with respect to conceptualising self and identity and knowing how best to account for the factors contributing to personality pathology.

A closer look at the DSM V proposal

The DSM V proposal for personality disorders recognises both *interpersonal* personality functioning (e.g., a capacity for empathy and intimacy) and *intrapersonal* personality dimensions. The proposed understanding of intrapersonal personality functioning encapsulates two core components: *self* and *self direction*. The *self* component entails a sense of *identity*, which involves both a sense of uniqueness as well as clearly defined boundaries between self and others. Additionally, identity also includes processes contributing to emotional regulation and accuracy of self-appraisal. On the other hand, *self-direction* refers to pursuing coherent and meaningful short and long term goals, utilising constructive and prosocial internal standards of behaviour, as well as being able to productively self-reflect.

Self and identity

Historically, the term 'self' has come to be understood in many ways but two common threads can be discerned in accounts of self generally. One of these refers to the 'self' as the *knower* within the personality. This sense of self is often used interchangeably with 'ego' (Latin: "I") standing as the *subject* that experiences and is often bound up with being 'conscious' of states of affairs, including itself. On the other

hand, 'self' is also treated as that which is *known* (the object of cognition or 'self-concept'). While sometimes the self as knower and self as known are conflated, we can recognise that persons only more or less reflect upon their 'selves', which raises question concerning the factors related to self-reflection and distortions or omissions of self-knowledge. In the DSM V proposal the knower's self-knowledge is at issue, and the most severe personality dysfunction includes a profound inability to constructively reflect upon one's own experience.

'Identity' is intimately bound up with the self as both knower and known and can be conceptualised as something that we *do* with respect to accepting or rejecting what exists within the boundaries of the self ('I am this but not that'). For example, a person might or might not identify with their family, might or might not identify with their culture of origin, and might or might not identify even with his or her own bodies (as in gender identity disorder or *gender dysphoria*). What we call identity then is simply a label for the sum total of the various identifying relations that the person enters into. Such identifications need not necessarily be either wanted or even known or recognised, and with respect to personality disorders the identifying relationship is often distorted and contains both notable inclusions and omissions. For instance, in the case of narcissistic personality disorder we might find on the one hand a one-sided identification with grandiosity, while on the other the sometimes violent exclusion of self-discrepant information.

Disturbances to self-reflection

Undoubtedly a variety of biological, psychological and social factors may contribute to any of the respective personality disorders. It is interesting, however, to note that whatever the causes of any particular disorder might be, under the DSM V proposal all personality disorders entail disturbances to self-reflection. In fact, the DSM V proposal posits that normal or non-disordered personality functioning includes 'accurate self-reflection', a position echoing Martin's (1952) proposal that "normality is a matter of objectivity; of seeing things as they are" (p. 28). While some might question this account—citing the findings concerning positive illusions and depressive realism (Taylor & Brown, 1988)—the emphasis here upon self-reflection in both the 'self' and 'self-direction' component is interesting theoretically since it indicates that the clinician will be interested in any process that might facilitate or inhibit self-reflection.

There are several possibilities underlying failures of self-reflection. One includes developmental failures of self and identity integration. For example, evidence from attachment and psychodynamic research indicates that individuals have important developmental needs that can only be met relationally. Relational privation here can critically contribute to long-standing neurological changes related to failures in knowing one's own and others' minds (Fonagy & Target,

2008). Similarly, some early trauma research indicates extreme dissociative responses and failures of ego development arise in response to extreme inadequate object-relations (e.g., Schore, 2009).

Alternatively, the DSM V proposal for personality disorders also appears to implicate a revived appreciation for other psychodynamic processes that impact upon self reflection. For instance, extreme personality dysfunction is characterised by failures in recognising one's own motives and experiencing these as external to oneself (i.e., projection). There are a variety of other psychodynamic processes that might also be relevant here — such as repression, suppression, splitting, dissociation—some of which may be simply descriptive labels or posited as explanatory mechanisms accounting for failures in self-reflection. For example, 'dissociation' is generally a descriptive term (a lack of association) and a variety of mechanisms might subserve any observed dissociation. In any case, whatever aetiological factors contribute, the role of psychodynamic processes appear to be paramount for understanding the mechanisms underlying much of personality pathology.

Culture and the self

The increasing appreciation for possible cultural differences with respect to self and identity poses important questions with respect to the cultural appropriateness of the DSM V. The most recognised cultural distinction here proposes cultural differences between *independent* and *interdependent* self-construals. Here Westerners are characterised by relatively clear boundaries between self and others, whereas Eastern interdependent self-construals are generally defined in terms of others (e.g., social roles) (Markus & Kitayama, 2010). As several authors rightly note, if such cultural distinction have merit then there are important implications for psychotherapy, both in terms of aetiology and treatment (e.g., Hall, 2003). Furthermore, such cultural considerations require careful consideration when postulating any account of personality pathology.

On the face of it, the DSM V proposal could be accused of bias towards the western viewpoint, where the emphasis is on the bound and unique self. Consequently, the DSM V proposal could be accused of potentially pathologising non-western self-experiences. However, the independent-interdependent dichotomy has been found to grossly exaggerate the differences between Westerners and Easterners by oversimplifying the nature of 'culture' (Bandura, 2002). Furthermore, any individual can be seen as having *both* independent and interdependent identification, no matter where in the world they originate from (Raef, 2004). Nevertheless, while the usefulness of the cultural dichotomy may be questionable, cultural sensitivity nevertheless demands critical self-appraisal concerning whether our personality theories are universal or instead represent lopsided approaches based on cultural chauvinism (Leising,

Rogers, & Ostner, 2009). Accordingly, the cross-cultural adequacy of the DSM V proposal requires further careful consideration.

Summary

The proposed changes to personality disorders in the DSM-V indicate a renewed focus on identity and self as key components in personality. This entails careful scrutiny of what self and identity refer to, as well as careful scrutiny with respect to the processes underlying personality pathologies and their development. The component of self-reflection disruptions in personality disorders appears to breathe life into the significance of psychodynamic processes for understanding personality pathology. Nevertheless, cultural distinctions in self-experiences require careful consideration before pathologising self-experiences.

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THE EMPIRICAL (IR)RELEVANCE OF ATTACHMENT THEORY

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Introduction

Personality disorders (PDs), at least as constructed within the descriptive framework of the *Diagnostic & Statistical Manual* (DSM), have come a long way. From the courageous development of psychodynamic theories, infused with Kraepelian biologisms and a zest of behaviourism, onto a gestalt-like kaleidoscope of the hybrid dimensional-categorical model in the upcoming 5th edition of the DSM (DSM-V) – “the Future Manual”, as The American Psychiatric Association (2012) boldly declares on its webpage. The necessity for a major revision of the PD constructs has reached a critical point through the accumulation of irrefutable evidence that directed attention to major limitations in the current classification of the DSM-IV. The main issues of concern focus on the recovered poor to unacceptable convergence validity of assessment (e.g. Clark, Livesley, & Moray, 1997), large transient error of measurement (e.g. Zimmerman, 1994), heterogeneity of symptom manifestations (e.g. Clark, 2007), low discriminant validity of diagnosis and lack of construct specificity (e.g. Grant Stinson, Dawson, Chou, & Ruan, 2005), and the arbitrariness of diagnostic thresholds (e.g. Skodol, Gunderson, Pfohl, Widiger, Livesley, & Siever, 2002). The proposed restructuring of PD classification in the DSM-V aims to address these and other such issues. It does so by both adopting a multi-theoretical framework of cognitive-behavioural, developmental, dispositional (lexical and psychobiological), (behavioural and molecular) genetics, evolutionary, neuroscientific, psychodynamic, and sociocognitive approaches to personality and personopathology, and utilising knowledge gained from the most relevant and congruent research-based evidence of these approaches. Consequently, the current proposal of the DSM-V retains six, albeit largely augmented, specific PD types, viz. *antisocial* (ASPD), *avoidant* (AVPD), *borderline* (BPD), *narcissistic* (NPD), *obsessive-compulsive* (OCPD), and *schizotypal* (STPD), which are dimensionally assessed on two sets of criteria: five levels of impairment in personality functioning, as expressed through a *self-interpersonal* continuum (Criterion A), and a descriptive rating on five, rather obliquely related, personality domains (viz. *negative affectivity*, *detachment*, *antagonism*, *disinhibition*, and *psychoticism*) comprising a total of 25 trait facets (Criterion B).

Within the above system, the diagnostic importance of dysfunctions in dyadic interpersonal relationships (mainly as expressed within parent-child or romantic partner dyads) is implicitly present in the interpersonal dimension of *intimacy* of criterion A and in the criterion B personality domains, such as negative affectivity and detachment. The attachment conceptualisation of dyadic interpersonality offers a broad theoretical matrix with both distal and proximal value of antecedence that is capable of explaining relational dysregulation. The current paper systematically reviews the empirical evidence on the association between attachment constructs and the DSM personality pathology, attempts to

clarify the above association and offer directions of valuable utility to the DSM-V diagnostic reconceptualization of PDs.

Attachment Theory

Attachment experiences are regarded by John Bowlby (1969/1982) as the “foundation stone of [one’s] personality” (p. 177). They reflect the functioning of a core biobehavioural safety regulation system, where an individual utilises close others – via proximity-seeking, support seeking or evoking mental representations – to obtain physical protection and/or emotion regulation, in both infancy and adulthood (Bowlby, 1969/1982; Mikulincer & Shaver, 2007). An important outcome is the alleviation of distress and achievement of felt security, indicative of effective interpersonal stress regulation (Sroufe & Waters, 1977). Coupled with biological disposition, one’s reoccurring attachment experiences build up neurobiological pathways of stress regulation and further influence the organisation of one’s personality (Schoore, 2002).

While the availability and responsiveness of one’s attachment figure results in relief from distress, failure to obtain this response leads to the adoption of secondary attachment strategies of hyperactivation and deactivation (Cassidy & Kobak, 1988; Shaver & Mikulincer, 2002). Hyperactivation occurs when proximity-seeking remains a viable option and manifests as the exacerbation of distress, heightened efforts to gain the attention of the attachment figure, and hypervigilance towards and rumination on threat and attachment cues. Conversely, when proximity-seeking is not possible or futile, deactivation of the attachment system occurs where there is suppression of distressful threat- and attachment-related emotions and cognitions and distancing of self from the attachment figure (for a review see Shaver & Mikulincer, 2002).

Although these secondary strategies provide effective short-term defence, chronic hyperactivation or deactivation is viewed as dysfunctional and characterises insecure attachments (Mikulincer & Shaver, 2002). A continually activated attachment system, which defines chronic hyperactivation, results in a bias towards relational threat cues and an overly strong desire for intimacy at the expense of individualistic pursuits and self-regulation. Generally, these individuals fail to achieve stable felt security, and difficulties notably arise in interpersonal situations where real or imagined cues of abandonment prompt extreme distress. In contrast, chronic deactivation manifests as the suppression of any threat cues and avoidance of interpersonal exchanges that may activate the attachment system. Such individuals tend to have a “compulsive self-reliant” personality and value independence and non-relational preoccupations, but when a major stressful event inadvertently activates the attachment system, they become distressed and are unable to effectively engage in interpersonal stress regulation (Bowlby, 1969/1982).

These tendencies toward hyperactivation and deactivation further characterise the dimensions of attachment anxiety and avoidance respectively, which are commonly adopted in research to describe individual differences in attachment behaviour (Mikulincer & Shaver, 2007). Attachment anxiety refers to the degree of worry over the attachment figure’s availability and responsiveness, while attachment avoidance refers to the degree of discomfort with intimacy and preference for emotional distance (Brennan, Clark & Shaver, 1998). Location on this two dimensional space in turn describes four attachment styles: secure, anxious (or ambivalent), dismissing-avoidant and fearful-avoidant (or disorganised). A summary of the characteristics of the different attachment styles is presented in Table 1.

Table 1. Characteristics of the Attachment Styles

Attachment style	Attachment dimensions	Secondary strategies	IWMs
Secure	Low anxiety, low avoidance	N/A	(+) Self, (+) Others
Anxious (ambivalent)	High anxiety, low avoidance	Hyper-activation	(-) Self, (+) Others
Dismissing-avoidant	Low anxiety, high avoidance	De-activation	(+) Self, (-) Others
Fearful-avoidant	High anxiety, high avoidance	Dis-organisation	(-) Self, (-) Others

Note. (+)/(-) self = positive/negative model of self; (+)/(-) others = positive/negative model of others

In addition to these patterns of interpersonal behaviour, long-term attachment experiences contribute to stable mentalisations or *internal working models* (IWMs) of self and others (Bowlby, 1969/1982). These models concern whether oneself is judged to be worthy of love and support (model of self) and whether others are perceived as trustworthy or unreliable and rejecting (model of others) (Bartholomew & Horowitz, 1991). As with the secondary attachment strategies, the models of self and others map onto the attachment dimensions of anxiety and avoidance respectively, and in combination provide interpersonality profiles of individuals with differentiated attachment styles (see Table 1). These IWMs are central to self-regulation and personality organisation, particularly with regards to the coherence and functionality of self within the relational context.

Attachment and Personality Disorders

In 2001, Kim Bartholomew and colleagues published a seminal 35-page long (syn)thesis on the relationship between attachment and personality disorders, both at theoretical and empirical levels. Their conclusion was that

“Much more work is needed in mapping out the associations between personality pathology and forms of attachment insecurity [...].The current body of research [...] is plagued by inconsistencies in

methods of assessing attachment [...] and personality disorders, and [...] by reliance on small clinical samples with little range of disorders" (p. 225).

Their warning was arguably ignored, as evidenced in Fraley and Shaver's (2008) one and a half page long updated review of partly theoretical connections between attachment and general personality dysregulation not exclusively bound to the DSM constructs. In the 2010 edition of the *Handbook of Attachment* (Cassidy & Shaver), PDs received just a few lines of mention, while, in a reverse focus manner, attachment is not at all mentioned in Millon's 2011 edition of *Disorders of Personality*. Fast-forward to today and tragically the picture does not seem to have changed much. Such lack of research activity appears incomprehensible, especially since the research agenda for the development of the DSM-V, as deposited by the APA taskforce (First et al., 2002), has already explicitly stated the immediate need for empirical evidence on the role relational problems – of which attachment is arguably a fundamental component – play in the aetiology, comorbidity, diagnosis, and treatment of mental disorders.

In order to minimise implicit biases in our unenthusiastic impression of the current state of evidence between the two constructs, we executed a literature search by utilising systematic review protocols. In doing so, searches were performed on PsycINFO, PubMed, ScienceDirect, and Web of Science electronic databases for peer-reviewed, already published or still in press, articles that reported original empirical research findings in English and used the terms "attachment" and any of the terms "personality disorder", "antisocial", "avoidant", "borderline", "narcissis*", "obsessive AND compulsive", or "schizotyp*" as either keywords, title, or abstract words. Additionally, the earlier publication search date was restricted to 1994 (the publication of the DSM-IV). A pro-forma of specific criteria was devised to assess eligibility of inclusion of the screened articles. Only research that involved DSM personality constructs was considered, while studies on exclusive psychodynamic ideas, counselling approaches, psychometric scale development, or non-DSM perspectives of, say, antisocial behaviour, were ignored. Also, studies were not considered if they only assessed PDs that are not part of the DSM-V structure (e.g. paranoid, schizoid, or histrionic). When the searches returned reviews, systematic reviews, or metaanalyses, the studies discussed in those articles were considered for inclusion, but not the articles themselves. Furthermore, the following journals were independently searched: Archives of General Psychiatry, Journal of Abnormal Psychology, Journal of Personality Disorders, and Personality Disorders. When article inclusion classification uncertainty was identified, it was discussed by the two authors and a consensus was reached. Finally, the references of the included articles were manually screened for potentially relevant papers that conformed to the pro-forma criteria. The main points of relevance in the final article cohort are summarised in Table 2.

The first, and rather obvious impression is that the systematic literature review identified only 34 studies during the past 18 years that directly assessed the association between attachment and PDs. Of these studies, 13 (38.2%) were conducted on exclusively nonclinical cohorts, 14 (41.2%) on exclusively clinical ones, and 7 (20.6%) used mixed clinical-nonclinical samples. PDs did not have the same level of assessment coverage, with BPD being the most commonly assessed one (present in 30, 88.2% of studies), either exclusively or in combination with other PDs, followed by STPD (present in 18, 52.9% of studies) and AVPD (present in 15, 44.1% of studies) – in fact, BPD and STPD were the only ones that received exclusive research foci.

Despite the scarcity of studies, the reviewed evidence presents a rather unambiguous picture that adequately complies to the theory. In all studies (except [22] that found no statistically significant relations within an "artificially healthy" cohort) personality pathology was characterised by low attachment security and high attachment insecurity, when compared to healthy cohorts or norms. This suggests that insecure attachment orientations form a core feature of PDs, which is unsurprising since the psychopathologies are defined by impaired interpersonal functioning and regulation. Although these findings may be construed as artefacts of definitional circularity, rather than honest representations of the underlying connections, most of the reviewed studies stated propositional criteria and attempted to fit study variables within broader nomological networks that arguably increase confidence in the validity of the recovered relationships. Furthermore, a differential, albeit possibly clusterised, association between insecure attachment and PD types was consistently evident. Specifically, phenotypic expressions of BPD symptomatology tended to be distinguished by elevated anxious, fearful, hostile, disorganised/unresolved, and preoccupied attachment schemata. Characteristic of these attachment profiles, BPD appears to involve extreme hyperactivation – a strong desire for intimacy, extreme distress towards relationship-threat cues, and protest behaviour – sometimes fluctuating with deactivation that results in disorganised attachment. Similarly AVPD and STPD appeared related to primarily avoidant and secondarily anxious attachment, while all three PDs were predominantly associated with a negative mental representation of the self. This was an expected finding, as the avoidance of attachment figures in the manner of deactivation to contain distress associated with failed interpersonal regulation may be typical of AVPD and STPD, while the self is also judged as unworthy of love and support, which corresponds to rejection concerns and discourages normative attachment behaviour. The evidence for the remaining DSM-V PDs is largely inconclusive, with, for example, NPD at times even exhibiting inverse relations to both attachment anxiety and avoidance.

Table 2. Systematic review study characteristics

Author (year)	Sample (% of women, when reported)	Main attachment measures	Main PD measures	Focal PDs	Key findings
[1] Aaronson et al. (2006)	90 clinical (82.2%)	RAQ	DIPD-IV	BPD (against OCPD)	(+) Angry withdrawal, (+) Compulsive care-seeking, (+) Insecure
[2] Alexander et al. (1998)	92 nonclinical female	FAI	MCMI	Various PDs	(+) Fearful, (+) Preoccupied/Avoidant: BPD
[3] Barone (2003)	40 nonclinical (62.5%), 40 clinical (62.5%)	AAI	SCID-II	BPD	(+) Preoccupied, (+) Unresolved
[4] Barone et al. (2011)	140 clinical (61.4%)	AAI	SCID-II	BPD	(+) Insecure
[5] Bender et al. (2001)	30 clinical	CAQ	MCMI	Cluster B	(+) Insecure: NPD, ASPD, BPD
[6] Berry et al. (2006)	323 nonclinical undergraduate (72%)	PAM	PS, SAS	STPD	(+) Anxious: Positive STPD; (+) Avoidant: Social Anhedonia
[7] Brennan & Shaver (1998)	1407 nonclinical undergraduate (58.3%)	RQ	PDQ	Various PDs	(-) Secure: all PDs; Various degrees of (+) insecurity in all PDs
[8] Buchheim et al. (2008)	11 clinical, 17 nonclinical (all female)	AAP	SCID-II	BPD	(+) Unresolved
[9] Choi-Kain et al. (2009)	109 clinical BPD, 44 clinical depression, 64 clinical non-BPD	RQ	SCID-II, DIB-R	BPD	(+) Preoccupied, (+) Fearful
[10] Crawford et al. (2006)	604 nonclinical	CIC	SCID-II, PDQ	Various PDs	(+) Anxious: Cluster B, C; (+) Avoidant: Cluster A, (-) Cluster B, C
[11] Fonagy et al. (1996)	85 clinical	AAI	SCID-II	Various PDs	(+) Preoccupied: BPD
[12] Fossati et al. (2001)	44 clinical BPD, 98 clinical non-BPD (other Cluster B diagnoses), 39 clinical (Cluster A or C), 70 clinical (no-PD), 206 nonclinical	ASQ	SCID-II	BPD (against the rest of conditions)	(+) Insecure: BPD against nonclinical and no-PD; similar levels of insecurity between BPD and the rest of the PD cohorts
[13] Fossati et al. (2003)	487 clinical (61.8%)	ASQ	SCID-II	Various PDs	(+) Avoidant: AVPD, STPD; (+) Anxious: BPD
[14] Fossati et al. (2011)	501 nonclinical high-school pupils (50.9%)	ASQ	PDQ	BPD	(+) Need for approval
[15] Fossati et al. (2012)	1192 nonclinical (57.9%)	ASQ	PDQ	BPD	(+) Anxious
[16] Hill et al. (2011)	58 nonclinical (study 1), 138 clinical (study 2) (all female)	AAI	SCID-II	BPD	(+) Preoccupied
[17] Hoermann et al. (2004)	41 clinical females	RQ	SCID-II	Cluster B	(+) Fearful/Avoidant: BPD
[18] Hooley & Wilson-Murphy (2012)	80 nonclinical (76%)	ECR	SNAP	Various PDs	(+) Anxious: STPD, ASPD, NPD, BPD
[19] Meins et al. (2008)	154 nonclinical undergraduate (56.5%)	RQ	SPQ-A	STPD	(+) Anxious: Paranoia & Negative STPD; (+) Avoidant: Negative STPD
[20] Meyer et al. (2001)	149 clinical (57%)	AP	SCID-II	Various PDs	(-) Secure: all PDs; (-) Excessive Dependency: (-) STPD, (+) BPD, AVPD; (+) Defensive Separation: STPD
[21] Meyer et al. (2004)	176 nonclinical undergraduate (82%)	ECR	SCID-II-SQ	AVPD, BPD	(+) Anxious: BPD; (+) Anxious & Avoidant: AVPD
[22] Meyer et al. (2005)	156 nonclinical (72%)	IPPA	SCID-II-SQ	AVPD, BPD	No significant relations
[23] Minzenberg et al. (2006)	40 clinical (88.5%), 25 nonclinical (88.4%)	ECR	SCID-II	BPD	(+) Anxious, (+) Avoidant, (+) Fearful, (-) Secure
[24] Nakash-Eisikovits et al. (2002)	294 clinicians reporting on adolescent patients	RQ	SWAP	Various PDs	(-) Secure: all PDs (+) Avoidant: STPD, NPD, OCPD; (+) Anxious: BPD (+) Disorganised: STPD, BPD, NPD, AVPD, OCPD

[25] Patrick et al. (1994)	24 clinical females	AAI	Psychiatric casenotes	BPD	(+) Preoccupied; (+) Unresolved
[26] Riggs et al. (2007a)	80 clinical (92.5%)	ECR, AAI	MCMI	Various PDs	(+) Unresolved: BPD, STPD; (+) Positive model of self: NPD, OCPD; (-) Positive model of self: AVPD, STPD, BPD; (-) Positive model of other: AVPD; (+) Positive model of other: NPD
[27] Riggs et al. (2007b)	80 clinical (92.5%)	ECR	MCMI	Various PDs	(+) Avoidant: AVPD; (+) Anxious: AVPD, STPD; (-) Avoidant: NPD; (-) Anxious: NPD, OCPD
[28] Rosenstein & Horowitz (1996)	60 clinical adolescents (46%)	AAI	MCMI	Various PDs	(+) Dismissing: NPD & ASPD; (+) Preoccupied: BPD & STPD
[29] Sack et al. (1996)	53 nonclinical undergraduate (94.3%), 49 clinical (89.8%)	ASI, RAQ, AHAS, HS	Clinical records	BPD	(+) Avoidant; (+) Hostile; (+) Ambivalent; (-) Secure; (-) Dependent
[30] Scott et al. (2009)	1401 nonclinical undergraduate (67%)	ECR	MSI-BPD	BPD	(+) Anxious
[31] Tiliopoulos & Goodall (2009)	161 nonclinical (68.3%)	ECR	SPQ-A	STPD	(+) Anxious: Cognitive/Perceptual & Disorganised; (+) Avoidant: Interpersonal
[32] Timmerman & Emmelkamp (2006)	39 clinical, 192 prisoners, 195 nonclinical (all male)	RQ	PDQ	Various PDs	(-) Secure: Cluster A & C; (+) Dismissing: Cluster A, (-) Cluster C; (+) Preoccupied: Cluster A; (+) Fearful: Cluster A, C; Unclear relations to Cluster B
[33] Westen et al. (2006)	150 clinical (study 1) 145 clinical (study 2)	APQ-A	Axis II checklist	Various PDs	(-) Secure, (+) Preoccupied, (+) Disorganised: BPD
[34] Wilson & Constanzo (1996)	273 nonclinical undergraduate (51%)	HS, AAS	SAE, PAMIS	STPD	(-) Secure; (+) Anxious: Positive STPD; (+) Avoidant: Positive & Negative STPD

Note. RAQ = Reciprocal Attachment Questionnaire; DIPD-IV = Diagnostic Interview for DSM-IV Personality Disorders; FAI = Family Attachment Interview; MCMI = Millon Clinical Multiaxial Inventory; AAI = Adult Attachment Interview; SCID-II = Structured Clinical Interview for DSM-IV Axis II; CAQ = Calgary Attachment Questionnaire; Pam = Psychosis Attachment Measure; PS = Positive Schizotypy; SAS = Social Anhedonia Scale; RQ = Relationships Questionnaire; PDQ = Personality Diagnostic Questionnaire; AAP = Adult attachment Projective; CIC = Children in the Community; ASQ = Adult Styles Questionnaire; DIP-R = Revised Diagnostic Interview for Borderlines; ECR = Experience in Close Relationships; SNAP = Schedule for Nonadaptive and Adaptive Personality; SPQ-A = Schizotypal Personality Questionnaire (form A); AP = Attachment Prototypes; IPPA = Inventory of Parent & Peer Attachment; SCID-II-SQ = Structured Clinical Interview for DSM-IV Axis II Screening Questionnaire; ASI = Attachment Style Inventory; AHAS = Attachment History Adjective Sort; HS = Hazan and Shaver's attachment self-report; MSI-BPD = McLean Screening Instrument for BPD; APQ-A = Attachment Prototype Questionnaire-Adolescent Version; AAS = Adult Attachment Scale; SAE = Survey of Attitudes & Experiences; PAMIS = Perceptual Aberration & Magical Ideation Scales

Attachment and dysfunctional traits

Following the same systematic literature search procedure to the one above, the aforementioned electronic databases were searched for peer-reviewed, already published or still in press, articles that reported original empirical research findings in English and used the terms 'attachment' and any of the trait domains or facets of the DSM-V PD criterion B assessment, as either keywords, title, or abstract words. For comparative consistency, 1994 remained the starting year of search. No restrictions on clinical content were imposed, thus studies conducted outside the PD or psychopathological sphere were also candidates for inclusion. However, only studies that defined the trait constructs in the same or in an acceptably similar manner to the DSM-V definitions (American Psychiatric Association, 2010) and directly empirically connected them to attachment were considered. Studies were also ignored if they only utilised the constructs of interest as independent factors in casual or inferential models, without providing direct empirical evidence for their connection. As the final cohort included a few hundred of studies, a decision was made to focus the tabular presentation on the personality traits and only cite a representative sample of references or

review papers that adequately summarised the relevant findings (see Table 3). That said, this approach was only necessary for the evidence on the domain of negative affectivity and the facets of emotional lability, anxiousness, depressivity, hostility and risk taking, while for the rest of the traits the actual final cohorts are cited.

The imbalance in the empirical coverage is forcefully evident; a plethora of concomitant literature paints a rather clear picture of the relation between attachment constructs and trait elements of primarily negative affectivity and secondarily disinhibition and detachment. Since attachment insecurity directly implicates emotion dysregulation and maladaptive coping, it exhibits unsurprising associations with the above traits. Contrastingly, direct evidence apropos of the more psychopathic or narcissistic traits of antagonism and the related facet-descriptors is palpably absent. Theoretically, these constructs can still be expected to reflect the absence of attachment behaviour, characteristic of dismissing-avoidant attachments. Concurrently, the evidence regarding primarily the domain of psychoticism and the facet of suspiciousness is

rather sparse or does not offer consensual conclusions, while it tends to be almost exclusively generated from within the domain of schizotypy research.

Epilogue

The DSM-V definition of PDs perceives impairments in interpersonal functioning as essential structural and diagnostic features of the constructs. Interpersonal relatedness possesses degrees of hierarchical dialectic transactions that manifest in (monadic), dyadic, triadic, and higher order interpersonality. Although dyadic relations can be understood through a variety of theoretical positions, e.g. object relations or other psychodynamic perspectives, the attachment paradigm has gained increasing influence within the personopathological discourse of the DSM. Yet, in the presence of a plethora of converging theoretical networks, linking the attachment and personality pathology constructs (e.g. Bartholomew Kwong, & Hart., 2001; Blatt & Levy, 2003; Cohen, 2008; Fonagy & Bateman, 2005; Lyddon & Sherry, 2001; Magnavita, 2004; Mikulincer & Shaver, 2012; Pincus, 2005) the level of research output identified in this paper is vexing and unfathomable. The nexus of attachment and personality dysfunction cannot certainly be accused of being atheoretical, unlike perhaps other nosological objects, classes, or connexions. Yet, it may still be accused of being non-evidence based or of evidence insufficiency that cannot support a justification for the central diagnostic inclusion of attachment-related constructs and dyadic enactments concomitants in the personopathological structure of the DSM-V. Should such accusation materialise, it may jeopardise the validity of clinical personality nosology and present a number of diagnostic and treatment dilemmas.

Although our review has recovered a decent body of evidence connecting attachment elements to primarily BPD and ASPD at both class and trait levels, the evidence regarding the rest of the PDs is still limited, inconclusive, or plainly absent. The directionality and segmentation of the reviewed literature may further suggest a research bias indicative of a construct validity limitation especially inherently present within the DSM-V trait descriptors. The narrative in the definition of traits arguably contains a systematic polarisation toward pathological descriptions that are still tightly linked to the official diagnostic nomenclature in such an orthogonal manner that limits, if not disallows, the generation of empirical knowledge that possesses generalizable utility. Thus, while further research may be conducted on direct and specific associations between attachment patterns and PD syndromes, this pursuit may ultimately be ineffective due to definitional and operational issues concerning the latter domain, and at best, offer descriptive insights.

Alternatively, as attachment insecurity is typically regarded as a general vulnerability factor to psychopathology (e.g. Bowlby, 1973; Mikulincer & Shaver, 2012), it may be more fruitful to uncover how attachment experiences influence the

development of pathological patterns of behaviour and cognitions that constitute the constellation of features defining personality disorders. Attachment theory is regarded as a theory of general personality development that accounts for the development of both functional and dysfunctional personality traits, especially within the context of interpersonal functioning (Bowlby, 1969/1982). Clearly, the theory has implications for the development of traits such as negative affectivity and detachment, along with general interpersonal functioning, to which our review has revealed preliminary empirical support. Connections with other traits and facets, although there is limited current knowledge, are potential future realms of research.

Another growing and prospective avenue is that of developmental psychopathology and epigenetics, which concerns how attachment experiences might interact with biological predisposition (e.g. molecular genetics) to have enduring effects on personality (dis)organisation and emotion (dys)regulation, and in turn, dispose one to personality pathologies. Integration of interpersonal neurobiology, epigenetics and developmental personopathology should further enhance understanding of the attachment-PD relationship, and subsequently enrich interpersonally-based diagnoses and treatments of PDs.

The desired outcome of these approaches is the development of a *truly* empirically-based diagnostic framework that describes the PD symptomology profiles with respect to their underlying development, thus taking into account both phenotypic multidimensionality within the pathologies and their aetiology that involves a major role for attachment experiences and biology, along with other environmental determinants. It remains to be seen whether the infusion of such knowledge reaches the architects of the DSM-V in time and results in this "Future Manual" living up to expectations of theoretical articulation and empirical promise, allowing for diagnoses to be more accurate, valid, and clinically useful.

Table 3. Attachment and criterion B (DSM-V) personality traits (facets present in multiple domains are only shown under the domain they first appear).

Domain	Facet	Attachment link	Literature
Negative Affectivity		Both dimensions	For review see Mikulincer & Shaver, 2007
	Emotional lability	Both dimensions; stronger links with attachment anxiety	For review see Nofte & Shaver, 2006
	Anxiousness	Both dimensions; stronger links with attachment anxiety	For review see Mikulincer & Shaver, 2007
	Separation Insecurity	<i>Unknown*</i>	
	Perseveration	<i>Unknown</i>	
	Submissiveness	Both dimensions	Irons & Gilbert, 2005; Pearson et al., 2010
	Hostility	Both dimensions Attachment anxiety Fearful attachment	Meesters & Muris, 2002; Muris et al., 2004; Somech & Elizur, 2011 Bonab & Koohsar, 2011; Cooper et al., 1998 Critchfield et al., 2007
	Depressivity	Both dimensions; stronger links with attachment anxiety	Franz et al., 2011; Gormley & McNiel, 2010; Kimball & Diddams, 2007; Lee & Hankin, 2009; Levesque et al., 2010; for review see Mikulincer & Shaver, 2007
	Suspiciousness	<i>Contradictory/unclear evidence</i>	Dozier & Lee, 1995; Marazziti et al., 2010; Somech & Elizur, 2011
	(lack of) Restricted affectivity	<i>Unknown</i>	
Detachment		Dependent attachment (inverse) Attachment avoidance	Bornstein et al., 2002 Renn, 2002
	Withdrawal	Attachment security (inverse) Attachment insecurity Dismissing attachment	Booth-LaForce & Oxford, 2008 Lapsley et al., 2000 Larose & Bernier, 2001
	Anhedonia	Attachment avoidance	Berry et al., 2006; Troisi et al., 2010
	Intimacy avoidance	Attachment avoidance	Land et al., 2011; Schachner & Shaver, 2004
Antagonism		<i>Unknown</i>	
	Manipulativeness	<i>Unknown</i>	
	Deceitfulness	<i>Unknown</i>	
	Grandiosity	Attachment security, dismissive attachment	Dickinson & Pincus, 2003
	Attention seeking	<i>Unknown</i>	
	Callousness	<i>Unknown</i>	
Disinhibition		<i>Unknown</i>	
	Irresponsibility	<i>Unknown</i>	
	Impulsivity	Attachment anxiety	Fossati et al., 2005; Scott et al., 2009
	Distractibility	Attachment anxiety Attachment insecurity	Silva et al., 2012 Warren et al., 2010
	Risk taking	Both dimensions; stronger links with attachment anxiety	Taubman-Ben-Ari & Mikulincer, 2007; Cooper et al., 1998; Morsünbül, 2009
	(lack of) Rigid perfectionism	Both dimensions; stronger links with attachment anxiety (inverse)	Chen, 2012; Dunkley et al., 2012; Pishva & Besharat, 2011; Rice et al., 2005; Rice & Mirzadeh, 2000; Ulu & Tezer, 2010; Wei et al., 2004
Psychoticism		<i>Contradictory/unclear evidence</i>	Figueredo et al., 2005; Koohsar & Bonab, 2011
	Unusual beliefs & experiences	Both dimensions Attachment anxiety	Berry et al., 2007 Meins et al., 2008
	Eccentricity	Attachment anxiety	Tiliopoulos & Goodall, 2009
	Cognitive & perceptual dysregulation	Both dimensions; stronger links with attachment anxiety	Berry et al., 2007; Tiliopoulos & Goodall, 2009; Wilson & Costanzo, 1996

* "unknown" indicates that we were unable to identify direct and explicit empirical evidence of construct relevance

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(Reviewed papers are preceded by an asterisk)

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THE CLINICIAN'S DILEMMA: CORE CONFLICTUAL RELATIONSHIP THEMES IN PERSONALITY DISORDERS

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Psychotherapy as a treatment for mental health disorders has been developing for almost 120 years (Norcross, VandenBos, Freedheim, 2010). This history is a rich one, with many millions of pages of text written about psychotherapy, analysing individual cases (Breuer & Freud, 1895/1955; Watson & Rayner, 1920); collections of cases (Jones, 1936); aggregating multiple sets of studies (Smith & Glass, 1977); and

doing large studies of many thousands of cases (Seligman, 1995). Much of the promise of the Boulder model of clinical psychology training (Raimy, 1950) is to add every trained clinician into the ranks of scientists who can join this discourse and investigation. The 'scientist-practitioner' is a useful rubric for understanding the clinical situation - a client struggling to present their story, and a clinician struggling to make sense of it, using a model of treatment informed by scientific theory and empirical outcomes (Weiner, 2012).

It is tempting to take this further to progress the view that clinicians can and should be taught to be dispassionate scientists performing technical tasks based on empirical procedures documented in manuals. As we know, however, the data from the science of psychotherapy are in, and the results show the necessity and value of therapeutic warmth, engagement and support in this process (Duncan, Miller, Wampold, & Hubble, 2010). The therapeutic alliance is acknowledged as one of the most powerful factors influencing therapeutic success (Martin, Garske, & Davis, 2000). This is now understood as a sophisticated interaction between the clinician and client - with both playing a role (Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). The role of the clinician is to provide a sensible explanation to the client with regard to the planned course of treatment and to demonstrate through their behaviour and attitudes that they will support the client on this journey. The role of the client is to be willing and able to work with the clinician on this plan. Our laboratory and those of others around the world are now focusing on this critical relationship between clinician and client. It is evident how complex this critical relationship becomes when severe mental illnesses, and particularly personality disorders, are involved (Lewis & Grenyer 2009).

Research on the science of personality was advanced with the discovery of the Core Conflictual Relationship Theme (CCRT) method. In 1976 Lester Luborsky, one of the great figures in psychotherapy research (Barber, Crits-Christoph, Grenyer, & Diguier, 2010), was carefully reading and re-reading verbatim transcripts of psychotherapy sessions trying to understand the therapeutic alliance when he discovered a pattern within the conversation between clinician and client (Luborsky, 1977). We know that clients come to therapy because they cannot master their problems (Grenyer, 2002). In trying to master them, they tell narratives to both engage the clinician in the task of problem solving, and to invite them to show support and empathy for their suffering. We know that clients who are older with more severe symptoms tell much more negative narratives compared to younger clients (Grenyer & Luborsky, 1998). Close inspection of narratives told by clients allow us to identify three common elements: (i) the wish (W) of the client in relation to the interaction; what they wanted or hoped for from the interaction (such as to get help), (ii) the response of other (RO); the client's understanding of how others responded to their wish, need or intention, (such as the other person rejecting them), and (iii) the response of

self (RS) - how the client responded to the interaction, such as by withdrawing or getting depressed. Thus can the clinician begin to get insight into the relationship between symptoms (the response of self, such as depression or anxiety) and their interpersonal concomitants - the expected, perceived, or actual responses from others. We know that the accounts of relationships given to us by our clients can be distorted (the identification of such cognitive errors was one of Beck's contributions) and the analysis of the RO to RS sequence goes a long way toward assisting joint understanding of the meaning of symptoms. The wish component introduces the motivational component of psychology. Identifying the needs, wishes and goals of the client in itself is an important step in formulation, but goes further to advance our understanding of the psychosocial maturity of the client in relation to the kinds of needs and wishes they present within the context of their development.

When clinicians begin to study these three components across multiple narratives, then a 'signature' CCRT pattern, or several patterns, emerge (Book, 1998). We might alternatively refer to this process as the 'self-fulfilling prophecy' or 'transference' or 'personality style' or 'attachment pattern', in that the client's characteristic attitudes and approach to relationships can be identified. When Freud first discovered this process he called it a 'stereotype plate' in reference to the metaphor of the steel printing press of his time that was capable of printing multiple copies of the same text or image reprinted afresh with each inking (Freud, 1912/1958). Today using more cognitive science language, we might call it a relationship schema (Young, Klosko, & Weishaar, 2003), or the CCRT (Book, 1998).

A client, Mark, recently told me about his concerns about attending therapy, and that he didn't feel it was helping. These conversations were preceded with many sessions discussing his difficulties maintaining interest at work as he didn't feel appreciated, and his disengagement from his wife and daughters who were busy attending dance classes most evenings. When I had previously asked about his earlier experiences, he related a narrative about when he once came home from school and his family were all celebrating the graduation of his older brother who had got straight 'A's in class. As well as being preoccupied with the brother's success, the father had remarked that with this success he felt completely fulfilled as a father. This made my client feel even more like there was no space for him in his father's heart or life. From a CCRT perspective, we could understand that his wish (W) to feel important for others was repetitively experienced as rejection by others (RO) - his father, boss, wife - and this fuelled his depression (RS) and avoidant personality disorder. We could also understand in the therapy that he expected me to also reject him, and he had accordingly begun to withdraw from therapy and our relationship. It was only by working through this core pattern, by understanding and learning to recognise it in multiple parts of his life, that he could begin to question and change his usual pattern of the

expected RO or rejection, which would lead him to instigate interpersonal withdrawal, and thereby confirm his expectation of rejection from others. Thus could we both understand the dilemma of him getting close to me, yet without that closeness he would remain unhelped.

Attending to narratives, as a scientist collects data, allows us to aggregate our understanding of what has gone wrong in the client's life through the multiple relationship conflicts affecting the ability to productively love and work. The hallmark of those with good mental health is the ability to satisfy their wishes through mutually enhancing and rewarding interpersonal relationships contributing to generativity and meaning.

Personality disorders are unfortunately common in mental health. In recognition of this, a large team of us from Wollongong, Sydney and Melbourne have been undertaking a major project for NSW Health to raise awareness and improve treatments, called the Project Air Strategy for Personality Disorders (www.projectairstrategy.org). Estimates suggest that 31.4% of patients with common Axis I disorders (such as anxiety and depression) also have a personality disorder (Zimmerman, Rothschild, & Chelminski, 2005). The presence of personality disorder complicates the clinical picture, and this is where tools such as the CCRT can assist the clinician both in the session and in supervision. Thus, in supervision I discussed my relationship with Mark and found, through an analysis of the RO component, that I too was withdrawing from him because of out of awareness feelings that he was rejecting me. Analysing the RO allowed us to find my counter-transference was mirroring his transference. Thus we were able to prevent a repetition of the CCRT in the therapy relationship.

We have recently been studying in more detail the challenges clinicians face in working with borderline personality disorder (BPD). With my colleague Marianne Bourke, the technology of the CCRT has shown that it is not the symptoms of BPD, such as self-harm and affect dysregulation that worries therapists most (Bourke & Grenyer, 2010). Rather, it is the characteristic RO the therapist experiences from the client. What makes maintaining therapeutic consistency and composure a key challenge is the client's interpersonal hostility, criticism, rejection and withdrawal towards the clinician. Remarkably, neuroimaging and social cooperation research with BPD has reinforced how client's social deficits in understanding the RO - or other's minds - predicts and explains the therapist's dilemma (King-Casas, Sharp, Lomax-Bream, Lohrenz, Fonagy, & Montague, 2008). Indeed, one approach to BPD, mentalisation based therapy (Bateman & Fonagy, 2009), has been devised to specifically target the client's incapacity to understand others, otherwise known as reflective functioning. Other findings with Phoebe Carter in our laboratory have shown how BPD clients' poverty of speech in describing their internal world magnifies the difficulties therapists face in making progress (Carter & Grenyer, 2012).

In relation to the treatment of personality disorders, therefore, it is clear that attending to the therapeutic relationship is a key challenge and the CCRT provides a key tool to help the clinician and supervisor. In fact, our recently developed clinical guidelines for personality disorders are based on a relationship model (Project Air Strategy, 2011). The model emphasises three relationships as the key to treatment: the relationship between the client and themselves (which sadly is often full of toxic attacks on self-esteem), the client and the clinician (as described above), and the client and the health service (which unfortunately can be equally rejecting (Department of Health, 2003)). Here we see the clinicians' dilemma in working with personality disorders - the need to get interpersonally close, which in turn stirs up the core conflicts in the client, which then spill into the therapeutic relationship inside and outside the room. The good news, however, is that by maintaining composure and thoughtfulness, good work can be done and the long term prognosis for people with personality disorders is turning out to be quite positive (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012).

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THE NATURAL COURSE OF PERSONALITY DISORDERS

Professor Conor Duggan, PhD, MD, OBE

Conor Duggan is Professor of Mental Health at the University of Nottingham and Head of Research and Development at partnerships in Care U.K. He was until recently a Honorary Consultant Psychiatrist at Arnold Lodge, Regional Secure Unit in Leicester, a treatment facility for men with personality disorder and a history of serious offending.

Professor Duggan's research interests are treatment efficacy in personality disordered offenders, their long-term course and the neuropsychological basis of psychopathology. He was Editor of the Journal of Forensic Psychiatry and Psychology until 2012 and has recently chaired a NICE Guideline Committee on the treatment of Antisocial Personality Disorder. He was awarded an OBE in July 2012 for his services to mental health.

"The follow-up is the great exposure of truth ... it is to the psychiatrist what a post-mortem is to the physician."

Peter Scott (1960)

Knowing the natural course that different personality disorders follow is important for three reasons. First, those who suffer from the condition (and their carers) can reasonably expect to be told how long it might last and what can be done to ameliorate it. Second, knowing the natural course is essential in assessing the efficacy of an intervention. If, for instance, the natural course of a condition remits quickly, irrespective of any intervention (e.g. the common cold), then, there is clearly little point in intervening. Conversely, a condition that is persistent over time and significant in its impact – which personality disorders are by definition (DSM-IV) – suggests that they might be suitable candidates for an intervention. Finally, one way of validating diagnostic entities is if they follow a predicted course (Robins & Guze, 1970). Despite these imperatives, surprising gaps in our knowledge of the natural history of many personality disorders continue to exist.

A useful starting point is a review by Michael Stone entitled *Long-term outcome in personality disorders* (Stone, 1993). While Stone implied in his title that the duration of the follow-up is important, this is but one of many design issues which plague this field. As Stone noted (and this still remains the case), researchers have produced the most compelling evidence on the course of borderline personality disorder

(BPD) so that is where we shall begin before considering the information on other personality disorders.

Borderline Personality Disorder (BPD)

From the 1980s onward, a number of long term investigations into the course of those with BPD were undertaken that compared their course with other major mental illnesses (e.g. schizophrenia). A consistent finding from these longer-term naturalistic studies (many of which were from residential settings) was that the course of BPD was substantially better than other major mental illnesses. These studies showed that, although those with BPD go through a difficult time in their 20s and 30s, they appear to grow out of their difficulties in their 40s to lead a more normal life (McGlashan, 1986a; Stone, 1987; Paris, Brown, & Nowlis, 1987). For instance, two thirds of those followed-up were well – a substantially greater number than those with major mental illnesses. Despite this, they did not entirely catch up with their peers who had already passed through comparable developmental stages in their lives (i.e. having a settled occupation, the development of a family etc.). A second important caveat to this positive outcome is that the presence of other co-morbidities (e.g. major depression, alcohol and/or drug misuse) – many of these being so common that they might be considered to represent some aspects of the disorder itself – was found to have a marked detrimental impact on their outcome. For instance, while the incidence of suicide among those with BPD was only 6% during Stone's (1987) follow-up; this rose to 39% when the BPD was co-morbid with major depression and alcohol misuse. Nonetheless, the results from these studies suggested that long-term course of BPD was very much better than expected when viewed from the midst of their crises when they were in their 20s.

A recent study which brings our thinking on the course and outcome of BPD up to date is the McLane Study of Adult Development (MSAD; Zanarini, Frankenberg, Hennen, Reich, & Silk, 2005) which, unlike those previously described, is a prospective, community study. Although the study has gone on for much longer, its main findings at 6 years were that 'remissions' were common (i.e. 74% failed to meet criteria of BPD at 6 years of follow-up). In addition, – and this was more surprising – once remission had occurred, then the rate of recurrence was only 6%. Again, the number of suicides were also less common than anticipated (4% versus an anticipated 10%). They concluded that BPD is best represented by a complex model that encompasses both acute symptoms (e.g. self-mutilation, chronic help-seeking behaviour) which resolve rapidly and other 'symptoms' (e.g. chronic feeling of intense anger and abandonment) that resolve much more slowly. Again, reiterating the earlier observation of McGlashan (1986a), they noted that even the successful BPD patients were still "...belatedly achieving the milestones of young adulthood."

Antisocial Personality Disorder (ASPD)

In contrast to an improving course with age in those with BPD, the longer-term course of those with ASPD is considered to be less favourable with Stone observing that '...the presence of ASP betokens a pessimistic prognosis and an unfavourable trajectory as tracked by outcome studies' (Stone, 1993). Even though criminal behaviour – often a concomitant of ASPD – may reduce with age (as it does in criminality in general) this reduction is not necessarily associated with an improvement in other aspects of the individual's personality. For instance, in one of the very few long-term follow-up studies of men with antisocial personality disorder, Black, Baumgard, and Bell (1995) showed that even in those men who had reduced their criminal behaviour, several undesirable personality characteristics remained that led to interpersonal difficulties. The presence of antisocial traits also has a negative effect in the treatment outcome of drug (Woody et al., 1985), and alcohol (Rounsaville, Dolinsky, Babor, & Meyer, 1987) misuse.

Narcissistic Personality Disorders (NPD)

Here the information is very sparse. Plakun (1989) compared those with NPD with those with BPD found that the former had more admissions together with a poorer level of functioning. It is also hypothesised that those with narcissistic features might be particularly vulnerable to suicide.

Cluster A

Generally few data but the received wisdom is that those in Cluster A have a chronic or even worsening course over time (Paris, 1993). For instance, McGlashan, (1986b), found that those with Schizotypal Personality Disorder – which some regard as a variant of schizophrenia – remained very impaired with their outcome evidencing considerable social impairment, lack of an intimate relationship and under achievement in employment. Again, it is difficult to believe that those with paranoid personality who are mistrustful and suspicious of others would improve with age with the presence of such personality features explaining the difficulties in some elderly individuals who become dependent on others with increasing age. This clearly requires further study.

Cluster C and Other Personality Disorders

Stone observed that, despite the Cluster C disorders (Obsessive Compulsive PD, Avoidant PD etc.) being the most prevalent, our knowledge of their long-term natural course is minimal because of their ambulatory nature. They also overlap with many of the anxiety disorders within Axis 1. What evidence, as does exist, suggests that these disorders remain constant over time.

The Collaborative Longitudinal Personality Disorder Study (CLPD) is a prospective longitudinal study comparing the course in a treatment seeking sample of four specific Personality Disorders (i.e. Schizotypal, Borderline, Avoidant and Obsessional-Compulsive) with one another and with pure Major Depressive Disorder (MDD). They were followed-up annually and their 7 year outcome reported on in 2005 (Skodal et al., 2005). Their main finding were that, while PDs were more stable than MDD (as one would expect), nonetheless, half of the PD patients achieved 'remission' (i.e. with no more than two criteria of their baseline disorder for at least 12 consecutive months). Despite this, they confirmed that PDs constitute a significant public health problem with significant impairment, extensive treatment utilization and a negative prognostic impact on co-morbid depression and on suicidal risk. They concluded that PDs '...represented a hybrid of stable personality traits together with intermittently expressed symptomatic behaviours.'

When does personality disorder begin?

Although we conventionally define personality disorder as beginning at age 18, it is clear that the temperamental traits that produce personality disorder are present long before that date. What do childhood longitudinal studies tell us therefore about the genesis of personality disorder in adulthood? There are a number of these, but to focus on a couple of these. The first is the Children in the Community (CIC) Study of Patricia Cohen and colleagues who prospectively assessed and followed up 800 children drawn from a representative sample from upstate New York (Cohen, Crawford, Johnson, & Kasen, 2005). The sample has been repeatedly reassessed over a period of 29 years to examine inter-alia their early risks for personality disorder and the negative prognostic risk of adolescents PDs into adulthood. The findings were that mean PD 'symptoms' are highest in early adolescence with a linear decline thereafter of 1%/annum that ceased at an average of 27 years. However, 21% showed an increase in mean PD symptoms over the follow-up period. This follow-up study showed that PD constellations in adulthood have their origin in childhood, that these childhood characteristics have negative consequences for their attainment in adulthood (including suicidal attempts, violent and criminal behaviour, interpersonal conflicts) and finally that there was a complex interplay between genetic and environmental factors leading to PD in adulthood.

Longitudinal studies of youths who offend provide other important finding, namely, that antisocial behaviour persists and appears to be a stable developmental trait in some, whereas for many others (indeed the majority) it is transient (e.g. Farrington & Coid, 1993; Loeber et al. 1991). This is evidenced from two sources. First, there is the observation that only 30-40% of youths with conduct disorder as children or adolescents go on to become antisocial adults (Robins, Tipp, & Przybeck 1991). This identifies that (a) antisocial behaviour in adulthood almost always has its genesis in

childhood but also (b) that it is a persistent behaviour in less than half of those who behave in an antisocial manner before adulthood.

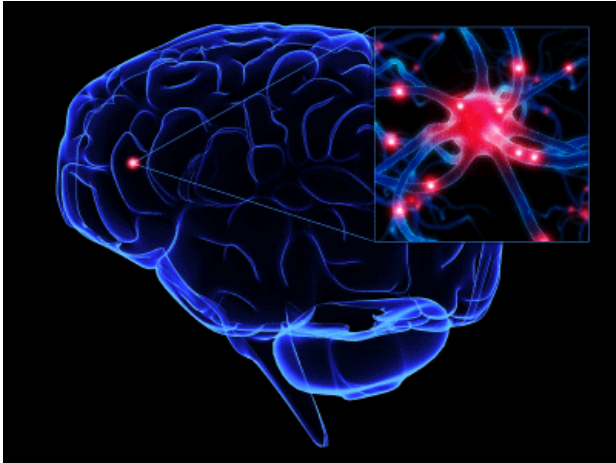
Second, by following up children into adolescence and adulthood in Dunedin, Moffitt (1993) describes two subgroups of young offenders: those with a 'life course persistent' (LCP) trajectory and those with an 'adolescent limited' trajectory (ALT). The LCP group, in which early onset antisocial behaviour persists throughout life, includes some individuals who later meet adult criteria for psychopathy. This LCP condition is believed to be triggered by an interaction between the child's difficult temperament (often associated with callous and unemotional traits) and poor parenting practices. Conversely, the ALT display antisocial behaviour later, experience less adverse early histories and are more influenced by delinquent peer pressure than the LCP group. If one accepts that there are some children who, as a consequence of their inheritance and their upbringing, are likely to develop difficulties in the future (i.e. the LCP group) – as these data clearly identify – this suggests the need for early identification and intervention with all the implications for further stigmatisation and marginalisation.

In conclusion, the scientific literature on the natural course of personality disorder is not extensive. That which does exist suggests that some personality disorders (e.g. BPD) the long-term course is more benign than one might expect but even here this conclusion is tempered by the individual trying to play catch-up with his/her normal peers. For many others, the course is either unknown or is blighted by persistent difficulties in interpersonal relationships and sense of self.

Measurement is a major problem. Put simply, if personality difficulties are short-lived so that they are amenable to change – are they really personality difficulties at all? Conversely, if they are immutable, so that they cannot change by definition, what is the point of intervening? The recent, better designed studies into the course of personality disorders, are attempting to integrate the transient with the more long-standing temperamental difficulties. These, in turn are leading to a radical revision of what we mean by the term 'personality disorder' with (a) several disorders disappearing altogether and (b) those that remain will have different criteria to define them. While there are undoubtedly good reasons for these changes, they will result in making it more difficult to interpret the meagre data on the natural course of PD currently at our disposal (Duggan, 2011).

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PERSONALITY, NEUROSCIENCE AND PSYCHOPATHOLOGY: THE BROADER VIEW

Phillip Corr, PhD and Giles Burch, PhD

Professor Philip Corr is Professor and Head of Psychology at the University of East Anglia, UK. He received his PhD on the biological basis of personality from the Institute of Psychiatry, London, where he was part of the Personality Research group, including, among others, Hans Eysenck. Philip has published over 90 scientific papers, largely dealing with the biological basis of personality and its relevance for understanding emotion, motivation and clinical disorders. He is the author of *Understanding Biological Psychology* (2006); editor of *The Reinforcement Sensitivity Theory of Personality* (2008); and joint editor of the *Cambridge Handbook of Personality Psychology* (2009).

Dr Giles Burch, who also received his PhD from the Institute of Psychiatry at the Maudsley Hospital, London, has a particular interest in workplace and organisational applications of RST (including work-related motivation, performance management and reward). Giles is a member of the Differential Psychology Research Group at the University of East Anglia.

The idea that psychological disorders are cut from the same cloth as 'normal' processes is neither new nor novel – Bleuler saw mental illness as an amplification of normal traits of personality. How can we best identify these processes? Well, if 'personality' reflects long-term stability in cognition, emotion and behaviour, and we view mental illness as an expression of dysfunctions in the systems that regulate these

stabilities, then there is a reasonable prospect of defining these systems by understanding the fundamentals of personality. How should we go about this task: which needle, and in which haystack?

As with the New York skyline, the further one is from the specific point of interest, the clearer the broad outlines of the landscape. There are many possible vantage points. A good one is the experimental work of Russian physiologist (and reluctant psychologist) Ivan Pavlov, famous for his work on the conditioned reflex; lesser known is his work on personality and its extension to psychopathology (see Gray, 1979). Towards the end of his career, Pavlov would attend ward rounds in hospitals and apply his concepts to 'neurosis' in human beings – out of this work came 'experimental psychopathology'. Biological psychologists applied his influence in psychiatry in the West, for example Slater's (1943) work on war neurosis.

Pavlov's work influenced generations of psychologists, most notably Hans Eysenck (1957) who established the broad psychometric and biological bases of personality, and, he in turn, influenced Jeffrey Gray whose first book (1964) was titled 'Pavlov's Typology'. Gray was to go on to a glittering career in psychology and laid the foundations for the neuropsychology of personality and psychopathology rooted in basic systems of emotion, motivation and learning.

Three Systems of Personality and Psychopathology

Gray's work has grown into a major theory known as *Reinforcement Sensitivity Theory (RST)* of personality. This contends that three major neuropsychological systems underlie emotion, motivation and behaviour, with individual differences in their functioning giving rise to personality and vulnerability to clinical (and forensic) disorders (e.g., Gray & McNaughton, 2000; McNaughton & Corr, 2004, 2008; for a summary, see Corr, 2008).

1. The **fight-flight-freeze system** (FFFS) is responsible for mediating reactions to *all* aversive stimuli. A hierarchical array of neural modules is responsible for avoidance and escape behaviours. The FFFS mediates the "get me out of this place" emotion of fear (but *not* anxiety). The associated personality factor is a fear-prone, avoidant person, which clinically maps onto such internalising disorders as phobia and panic.
2. The **Behavioural Approach System** (BAS) mediates reactions to *all* appetitive stimuli, and this system generates the hopeful emotion of 'anticipatory pleasure'. The associated personality is an optimistic, reward-oriented, impulsive person, which clinically maps onto such externalising behaviours as addictive behaviours (e.g., pathological gambling) and various varieties of high-risk, impulsive behaviour (e.g., psychopathy; see Corr, 2010).

3. The **Behavioural Inhibition System** (BIS) is responsible for the resolution of goal conflict in general (e.g., between BAS-approach and FFFS-avoidance), similar in essential respects to the classic work of Miller (1944) on approach-avoidance behaviour. The BIS generates the “watch out for danger” emotion of anxiety, which entails the inhibition of prepotent (automatic) conflicting behaviours, the engagement of risk assessment processes, and the scanning of memory and the environment to help resolve concurrent goal conflict.

The BIS resolves conflict by increasing, by recursive loops, the negative valence of stimuli (via activation of the FFFS), until behavioural resolution occurs in favour of approach or avoidance. Subjectively, this state is experienced as worry and rumination. The associated personality factor is a worry-prone, anxious person, who is constantly on the look-out for possible signs of danger, which clinically maps onto such internalising conditions as generalised anxiety disorder (GAD) and obsessive-compulsive disorder (OCD). The latter reflects a lack of adequate goal conflict resolution appropriate to local environmental conditions e.g., the door handle really does not contain life threatening viruses.

What determines which system is activated and, therefore, the vulnerability to internalising and externalising disorders? To start with, an important aspect of RST is that fear and anxiety are different, in terms of neurophysiology and pharmacology; and they are often opposing in their functions (e.g., the FFFS-related motivation to flee from the dentist's chair and the BIS-related behavioural inhibition evoked by the sound of the drill). In the clinical psychology and psychiatry literature, these two constructs have been conflated, and thus confused. Because of the detailed effects of anxiolytic drugs on behaviour (Gray & McNaughton, 2000), it is argued that the key factor distinguishing fear and anxiety is ‘defensive direction’: fear operates when leaving a dangerous situation (active avoidance; “get me out of here”); and anxiety when entering it (e.g., cautious ‘risk assessment’ approach behaviour; “watch out for danger”) or withholding entrance (passive avoidance; “reduced behaviour to avoid detection”) (McNaughton & Corr, 2004).

A second dimension is also important: ‘defensive distance’ (McNaughton & Corr, 2004). For the average individual in a particular situation, defensive distance equates with real distance; but, in a more dangerous situation, this perceived defensive distance is shortened. In other words, a defensive behaviour (e.g., active avoidance) will be elicited at a longer (objective) distance with a highly dangerous stimulus (corresponding to short perceived distance). People differ in their perceived defensive distance (threat perception, or fearfulness), and thus in their vulnerability to defensive behaviours that can take on clinical significance. For this reason, relatively weak aversive stimuli are sufficient to trigger a neurotic reaction in highly defensive individuals; but for a

less defensive individual, aversive stimuli would need to be much closer to elicit a comparable reaction. This set of relations is shown below.

Table 1. Relationship between fearfulness, subjective defensive distance and psychological state.

Level of fearfulness	Subjective Defensive distance	Psychological State
High.	Perceived distance less than actual distance.	Amplified threat reaction.
Normal.	Perceived distance equal to actual distance.	Normal threat reaction.
Low.	Perceived distance greater than actual distance.	Reduced threat reaction.

Thus, defensive distance can be seen to reflect an internal cognitive construct of intensity of perceived threat. It is a dimension controlling the type of defensive behaviour observed. In the case of defensive avoidance, the smallest defensive distances result in explosive attack, intermediate defensive distances result in freezing and flight, and very great defensive distances result in normal non-defensive behaviour. Thus, defensive distance maps to different levels of the FFFS and the BIS (see McNaughton & Corr, 2004) and, therefore, which behaviour is shown.

Defensive distance and clinical disorder

The psychological state experienced at very small defensive distance would be labelled panic. The commonly associated cognition in panic is “I’m going to die”. Intermediate defensive distances can be equated with phobic avoidance. With the opposite direction, defensive approach, defensive quiescence occurs at the closest defensive distances. At intermediate distances, risk assessment behaviour occurs and, at very great distances, defensive behaviour disappears and normal pre-threat behaviour reappears. Anxiolytic drugs alter (internally perceived) defensive distance relative to actual external threat. The neurology and pharmacological bases of these three systems is now extensive. A conceptual picture of how these systems relate to clinical disorders is shown in Figure 1.

Figure 1. Functional relations between different types of dangers and motivational and emotional outcome.

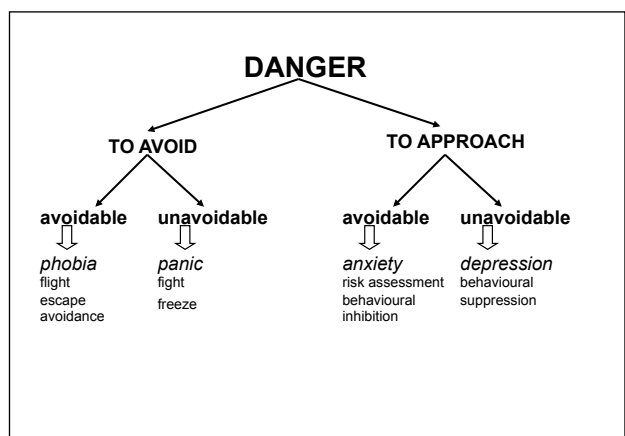


Figure 1 suggests that motivation and emotion are 'preprogrammed' by evolution; that is, specific reactions are elicited by the perception of different types of threat. These defensive systems have served our species well; however, they often fire-off inappropriately, especially in modern society where threat may be perceived when it is not really present. The good news for the clinician and patient is that the vast majority of threats are *perceived* and, therefore, subjective. Therefore, even if these systems are hard-wired – and they must be to a large extent – their operation can be affected by clinical intervention. Drugs dampen their sensitivity and activity; and psychological therapy can change inputs to the systems and, thereby, alter their outcomes (behaviours, emotions and symptoms). Cognitive behavioural therapy works altering the appraisal of threat and its cognitive consequences; this attenuates immediate defensive reactions and down-regulates the systems' sensitivity to future potential threats.

This broad outline of RST shows how specific disorders of interest fit into a larger conceptual landscape established on the grounds of fundamental knowledge of emotion, motivation and learning, and the consequences of individual differences in these systems: the 'personality-psychopathology continuum'.

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THE WOUNDED HEALERS: FRAGILE NARCISSISTS OR THE GUILTY GOOD?

Judy Hyde, PhD

Dr Hyde is Clinical Director of the University of Sydney postgraduate psychology training clinic and the first President of ACPA. She began her career in psychology working as a school counsellor in Kalgoorlie, completing her PhD at the University of Sydney. Her experience has included working with children, adolescents and families, as well as the supervision and development of the postgraduate psychology training programs at Macquarie University and then at the University of Sydney.

In 2010, Dr Hyde helped establish the Australian Clinical Psychology Association (ACPA) and has subsequently devoted herself to developing the organisation and promoting the expertise of qualified clinical psychologists to Government, the health professions and the public.

Psychotherapists are thought to be suited to their profession because of their own "personal wounds" (Guy, 1987, p. 1). Guy says that private pain is thought to give practitioners insight and empathy into the distress of others, whilst their survival and triumph over their difficulties gives them power and authority in the arena of personal distress. Goldberg (1986) claims that the practice of psychotherapy attracts and sustains the practitioner and provides avenues to salve their specific types of 'woundedness'.

Family of origin stress leading to interpersonal sensitivity (Menninger, 1957; Burton, 1975; Harris, 1975, as cited in Racusin, Abramowitz, & Winter, 1981; Guy, 1987; Goldberg, 1986; Sussman, 1992) has long been considered fundamental to the psychotherapist's career choice, particularly where coupled with superior intellectual development (Henry, Sims & Spray, 1973).

It has consistently been claimed that the majority of psychotherapists come from families in which serious problems exist (e.g. Miller, 1983; Goldberg, 1986; Guy, 1987; Sussman, 1992; Kottler, 1993 etc.). Basing his argument on the work of Henry and Burton in the seventies, Goldberg (1986) asserts that the majority of psychotherapists come from families in which grave physical or psychological problems of the parents, and the children themselves, were not resolved, and led to family relationships being in constant jeopardy. Psychotherapists report higher rates of physical abuse, sexual molestation, parental alcoholism, psychiatric hospitalization of a parent, death of a family member, and greater family dysfunction in their families of origin than other professionals

(Elliot & Guy, 1993). They also recall poorer family health, parent-child role reversal (with children assuming a caretaking role), ambiguous communication, less childhood happiness (Fussell & Bonney, 1990), and higher levels of maternal threats of abandonment, maternal attempts to do away with the foetus in the womb, and maternal miscarriages, stillbirths, or abortions (Burton, 1997) than comparison groups. Burton explains that such events would have rendered the mother at least temporarily emotionally unavailable to the child.

It may be, however, that the childhood experiences of psychotherapists are in fact no more problematic than others, but their awareness of their difficulties is greater. Levine, Barzansky and Blumberg (1983; as cited in Sussman, 1992) found that at admission to medical school, students who have a predilection for psychiatry could be identified by a single discriminating factor: the perception of personal or family problems of a psychological nature. Perception of psychological problems is affected by many factors, such as psychological awareness or mindedness, emotional attunement, insight, a lack of defensiveness and personal openness and sensitivity. However, particular psychological difficulties in childhood may also give rise to the attributes that lead to psychological perceptiveness.

Of greater utility and reliability, than directly comparing childhood memories, might be the development of an understanding of how specific types of 'wounding' childhood environments and experiences have explicit effects on the psychological development of the individual, leading to the evolution of particular personality styles, character traits, or defense structures, which culminate in the choice of the practice of psychotherapy as a career. The predicted outcome of these childhood experiences can be examined in the present, obviating the difficulties inherent in memory bias.

Goldberg (1986) asserts that the choice of psychotherapy practice as a career is "integrally related to the practitioner's unmet psychic needs" (p. 52). Roe (1990) centres the determinants of occupational choice firmly within the parent-child relationship, and claims that the emotional quality of this relationship is a decisive factor in this choice. She says that the "patterning of early satisfactions and frustrations is determined by the relative strengths of various needs and the forms and relative degrees of satisfactions they receive" (1990, p. 75). The intensity, organization and level of satisfaction of these needs determine which will become the strongest motivators.

The strength of the child's needs is augmented in an environment where there is delayed or intermittent satisfaction of these needs (Roe, 1990). Fussell and Bonney (1990) describe this as an emotionally 'ambivalent environment' and claim it provides the strongest predisposing factor for an individual to undertake a career as a psychotherapist.

Miller (1981) proposes that in childhood the psychotherapist is used by the mother to meet her own previously unmet emotional needs. The mother unconsciously controls her child's emotional responsiveness to her in order to obtain the awareness, responsiveness, soothing and understanding she did not receive from her own mother. It is specifically within this context that the personal qualities of the psychotherapist, such as sensitivity, empathy, responsiveness, and the capacity to read and respond to the emotional needs of others, are developed (Miller, 1981; Goldberg, 1986).

Miller (1981) calls these 'gifted' children and hypothesises that in the family these children are unconsciously 'selected' by the mother, precisely because they are intelligent, alert, sensitive, and capable of responding in accordance with the mother's wishes. This use of their attributes leads to the growth of the child's emotional perceptiveness and intuition, and ultimately results in the child taking on the role of confidante and comforter of the mother, and often responsibility for the siblings as well. Bowen (1976, as cited in Sussman, 1992) says that these children are the most emotionally attached in their families, receive the bulk of their parents' dysfunctional relating, and grow up with a fusion of emotional and intellectual functioning, making them most suited to, and most likely to engage in, the practice of psychotherapy.

To win the mother's love and approval, maintain her sense of security and power, and avoid her displeasure, Miller (1983) says the child needs to disavow parts of him/herself that are unacceptable to her. Normal aspects of the self, such as anger, aggression, jealousy, dependency, neediness, greed, and envy need to be 'repressed', or kept out of conscious awareness, and their emergence is strongly defended against. These disavowed aspects of the self remain, unintegrated, disowned and feared, but sensed; reposing in what Miller terms the 'true self' (after Winnicott, 1964), and which Goldberg (1986, p. 21) calls 'the magical or second (double) self'.

Miller (1981) explains this leads to a form of narcissism characterised by fragile self-esteem, perfectionism, denial of rejected feelings, a preponderance of exploitative relationships, an enormous fear of loss of love leading to conformity, over sensitivity, shame, guilt, and restlessness. Concurrently, the need to tune in to and respond emotionally to the mother results in "a special sensitivity to the unconscious signals manifesting the needs of others" (Miller, 1983, p. 23) with a "sensitivity, ... empathy, ... intense and differentiated emotional responsiveness, and ... unusually powerful 'antennae'" (p. 38). It is this particular form of fragile narcissism that Miller believes is characteristic of the psychotherapist. The narcissistic vulnerability of the psychotherapist portrayed by Miller, with its accompanying finely attuned empathy, may well be moderated by a distinctly depressive component to the characterological mix.

Indeed, many of the features of Miller's (1981) description may be seen as distinctly more depressive rather than narcissistic.

If, as is claimed, it is finely attuned empathy that distinguishes psychotherapists (Miller, 1981, Welt and Herron, 1990; McWilliams, 1994; Harton & Lyons, 2003), draws them to their profession, provides associated satisfactions with the work (Miller, 1983; Hall, Davis & Connelly, 2000), and enhances therapeutic outcome (Keijsers, Shaap & Hoogduin, 2000; Lambert & Barley, 2001), it may be the distinctly more depressive components, as opposed to the narcissistic elements of character, that are most relevant here. Empathy is considered to be a particularly depressive characteristic (Greenson, 1967; Kernberg, 1985). In contrast, narcissistic individuals are characterised as having (Kohut, 1971; Kernberg, 1985; McWilliams, 1994), and have been shown empirically to exhibit (Watson, Grisham, Trotter, & Biderman, 1984) a distinct lack of empathy.

McWilliams (1994) proposes that a substantial proportion of psychotherapists are characterologically depressive. She explains that depressive people often handle their unconscious dynamics by helping others. She says "we naturally empathise with sadness, we understand wounds to the self-esteem, we seek closeness and resist loss, and we ascribe our therapeutic successes to our patients' efforts and our failures to our personal limitations" (p. 229).

McWilliams (1994) says, "The combination of emotional or actual abandonment with parental criticism is particularly likely to create depressive dynamics" (McWilliams, 1994, p. 235). She explains that if 'gifted' children, such as those described by Miller (1983), are valued solely for their emotional gifts and are also scorned and pathologised for them, depressive dynamics will emerge and will be stronger than if the child were used only as a kind of family therapist. She says that depressive dynamics are founded on experiences of loss, either tangible or psychological, as has been shown empirically when depressive personality becomes disordered (Huprich, 2003).

In contrast to "narcissistically depressed people [who] are "subjectively empty" (p. 186) and lack "a sense of self" (p. 246), "characterologically depressive people...are subjectively full - of critical and angry internalizations" (McWilliams, 1994, p. 186), and have a "painfully negative" (p. 246) sense of self.

Miller (1981) describes an enormous fear of loss of love leading to conformity as one of the driving forces of fragile narcissism. Yet "the threat of loss of love" (Miller, 1983, p. 27) is more a depressive characteristic, where in fear that their own inner 'badness' drives away loved others, the depressive will "seek closeness and resist loss" (McWilliams, 1994, p. 229); and in trying to "preserve relationships at any cost" (1994, p. 231), will "try very hard to be "good" (McWilliams, 1994, p. 237), leading to conformity. In contrast, because for narcissistic individuals "the goodness of what the other has to offer is a

source of envy, dependency upon a loved object becomes impossible and must be denied; the narcissistic personality needs to be admired rather than loved" (Kernberg, 1995, p.151).

Over-sensitivity and fragile self-esteem are also identified by Miller (1981) as features of fragile narcissism. However, "because they are in a constant readiness to believe the worst about themselves, depressives can be very thin-skinned. Criticism may devastate them" (McWilliams, 1994, p. 238). This 'thin-skinned' quality of the depressive personality, arising from a pervasive sense of 'badness' due to repressed and internalised negative affects, may also have been a reflection of the over sensitivity and fragile self-esteem observed by Miller (1981), rather than attributes of the fragile narcissism to which it was ascribed.

Miller (1983) also considers split off aggression an attribute of the fragile narcissism of the psychotherapist. Yet, McWilliams (1994) explains that as a result of believing the worst about themselves, "depressive characters seldom feel spontaneous or unconflicted anger on their own behalf. Instead, they feel guilt" (1994, p. 230). Across studies it is consistently found that guilt-proneness is negligibly or negatively correlated with anger and hostility, while shame, the driving force of narcissism, "actually provoke[s] other-directed anger, rather than inhibiting anger and aggression (Tangney & Dearing, 2002, p. 110).

Sussman states, "reaction formations against aggressive strivings are thought to be characteristic of psychotherapists" (1992, p. 77). They result in a deeply felt, intrinsic and ego syntonic sense of 'badness', leading to enormous guilt, in contrast to the 'goodness' of the other; but offer a compensatory sense of control. If all 'badness' resides in the self one has control over it and can prevent it from being expressed and doing damage. Again it may be a more depressive component that leads the absence of anger and aggression in the psychotherapist.

"When aggressive impulses are heavily defended against, an individual's identity may centre around selfless giving and self-sacrifice" (Sussman, 1992, p. 74). Indeed, the most prominent insecure attachment style amongst a sample of clinical psychologists was found to be that of compulsive caregiver (Leiper & Caesares, 2000).

My own research, undertaken as a doctoral dissertation, found no evidence to support Miller's proposed fragile narcissism as dominant amongst Australian clinical psychologists, using the O'Brien Multiphasic Narcissistic Inventory (OMNI, O'Brien, 1987) with practicing, qualified clinical psychologists when compared to geologists and psychology academics. This self report questionnaire included a scale specifically designed to detect the type of fragile narcissism described by Miller (1983).

To determine if fragile narcissism might draw therapists to their career, but resolve through training and practice, a study was undertaken to compare applicants to postgraduate clinical and counselling programs with moviegoers using the OMNI and a further self report, the Narcissistic Injury Scale (NIS, Slyter, 1991), also developed to assess for Miller's proposed form of fragile narcissism. Again, there was no evidence to support Miller's proposal.

However, examining the profiles of qualified clinical psychologists using the Personality Adjective Checklist (PACL, Stack, 1991) adapted through the addition of a scale devised to measure the high-functioning depressive personality, female clinical psychologists of all orientations showed strong depressive dynamics. Male clinical psychologists showed low levels of depressiveness and tended to report an avoidant personality style, which Shedler and Westen (2004) suggest is an opposing strategy to cope with an essentially depressive core. Thus, both strive for closeness and connection: the female clinical psychologist tends to seek closeness directly within the therapeutic relationship; while for the avoidant male, the intimacy of the therapeutic relationship is made safe by the need for focus on the patient and away from the self.

This work has remained previously unpublished due to time constraints, but also because I would like to undertake a further study to ensure I have indeed, adequately captured the depressive elements of the high-functioning depressive. While the differences were strong, the validity of the scale used remains somewhat in question. When I step down from the role I play in ACPA I may turn to you for assistance in looking further into this fascinating mirror of who we are, why we are here and why we feel so passionate about our work.

In conclusion it may well be true, as Welt and Herron (1990) claim, that the concurrent need to be needed and to help others facilitates or "compels" the psychotherapist into their profession (1990, p. 26). For many of us, as Miller (1981) believes, the practice of psychotherapy provides a salve, enabling the practitioner to have his/her needs for intimacy unconsciously met and their feelings sanctioned without their conscious awareness.

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A CLIENT'S PERSPECTIVE: PERSONAL IDENTITY THROUGH THE LIFESPAN

Bea is a 49 year old woman who presented to therapy with intermittent panic attacks during her final year of a higher degree. Bea primary concerns were the state of her marriage and feeling that she was two separate people at home and in her academic life. This occurred in the context of Bea nearing the age at which her father died and her eldest child leaving home to study interstate. Bea is the eldest of five children and describes emotionally caretaking her mother during childhood and adolescence. Her father died whilst in her late teens. Bea's goals for therapy were to develop more robust boundaries and to be able to assert herself in her relationships.

I recently found my diary from 1988 and was struck by how I have changed since then. Many of the entries were about my relationships, with my husband, family and acquaintances. When writing about things that troubled me I often expressed physical sensations (stomach ache, choking, bloated) or emotions such as guilt, restriction, loneliness, or fear of change. There was a chasm between who I felt I had to be to be acceptable in my primary relationships and who I wanted to be. I wrote repeatedly about things without seeming to gain much insight or clarity. I was equally stuck in my postgraduate studies. I kept asking myself why was I not happy or settled, with either my marriage or my studies. I seemed equally disconnected from both, paralysed, unable to act or change. I had tried to analyse my actions and feelings but I seemed unaware of underlying beliefs, assumptions and habitual responses. And I was unable to get assistance because of pride, intellectual arrogance, and embarrassment.

Often I felt threatened and overpowered by others because I didn't know who I was or how to be in their presence. My poor sense of self was also reflected in the circumstances of my marriage – I had married young, attracted to an older, reserved, organised, self-contained person who embodied stability and order. I was not asked to share emotions, or express them. The relationship appeared to be a refuge from what scared and confused me.

I didn't keep diaries for most of the time since then, during which I got pregnant, dropped my studies and muddled through long years of child-rearing, volunteering and part-time work. Pregnancy and the preparation for and experience of homebirth launched me away from intellectual life into an intuitive way of being where I could feel more at ease, and was sometimes, ecstatically happy. Giving birth gave me a profound sense of self-worth and an awareness of my strengths. I was able to work with others while asserting my own needs. But the power and self-awareness I'd experienced in childbirth was dissipated by my focusing all my energy on

meeting others' needs. After too long being reactive, child-focused and unstimulated I lost all confidence in my intellectual abilities and felt like a drone running along a well-worn rut. Despite these being profoundly important experiences I couldn't talk about how I felt. I also couldn't relate the person I was as a mother to the person I was (or tried to be) as a professional adult. Almost unconsciously, I kept the two completely separate. I also maintained a split between my 'usual' self, and a different, more intimate and emotional self that I sometimes revealed within a few very close relationships.

A difficulty I have struggled with in trying to get a sense of self is being afraid to give up the facades and protections I have relied on to endure situations and relationships. Of course many if not all of these defences are ultimately counterproductive. I chose to be an organised, efficient, helpful, logical, patient person who finds out what others want and then adjusts accordingly. But perhaps people who wanted a genuine relationship with me sensed falseness in my behaviours and so my relationships could not develop past a certain level. My own feelings existed, but unnamed and unexpressed they retreated into depression and anxiety and I came to dread encountering the feelings of those closest to me.

How did my personal identity come to change? Partly because time passes, life events accumulate. The day-to-day compromises and glitches and rewards of domesticity bring contact with people and situations that enlighten, support, humiliate, delight and exhaust. Most helpful to me were friendships with much older women: learning about their lives, the situations they faced and responses and decisions they made.

It took a serious health scare and several deaths within my family to push me to change. I decided to return to study with the aim of resuming full-time work. Once I started studying, I became engrossed in the process of learning, not only the course itself, but through the people I met there. It was a sustained period where my need for time and space was justified by the demands of the course, so it seemed more possible to ask for that, without guilt. And because the course involved creativity and self-expression it became a catalyst not only for academic learning but also for learning about myself.

In the final year of my degree I returned to diary keeping as part of my creative practice. Sometimes when reflecting on my practice I had more personal realisations. When finding myself blocked with a deadline approaching I wrote "I think I need to cross over from one state to another in each project, from being outside the thing, 'doing' something to the materials, to 'being' inside or part of the thing. It might be a swap from conscious, intellectual thinking, to unconscious, intuitive thinking." Later I re-read it as a need also to reconcile my intellectual self and my emotional self into one.

I also allowed myself to admit that my usual defenses were failing and sought help. The process of talking with a

sympathetic, questioning clinical psychologist showed me new ways to think and act. Until then I had not even realised that I had a poorly formed personal identity, or that that was causing so many of the difficulties I had. Even to be aware was enough to defuse some problems, and it gave me a way of exploring and for the first time expressing some hidden feelings and odd behaviours which I had long ago considered to be fixed parts of my personality. I could also be present and honest in my marriage in a way I had long thought impossible, and far from destabilising it, there is now a sense of closeness and optimism. But life isn't a narrative and there is no neat resolution on this shifting terrain. From every insight and benefit new quandaries arise.

**Are you handy with a hyphen?
Particular about participles and
prepositions?**

Want to make a contribution to *your* ACPA?

The Editorial Board is looking for a **copyeditor** to volunteer their time to the tri-annual production of ACPARIAN. The role of the copyeditor is to work under the direction of the Editor to review submissions for grammar, syntax and punctuation. You'll need to have a keen eye for detail, advanced English language skills, a thorough working knowledge of APA style and of course, a passion for the advancement of clinical psychology. To find out more or to express your interest, please contact the ACPARIAN Editor, Kaye Horley - kaye@practicalpsychology.com.au.

ETHICS AND LEGAL DILEMMAS: THE ETHICS OF PERSONALITY ASSESSMENT

Giles Burch, PhD
Associate Editor

In an edition of *ACPARIAN* that is dedicated to personality, one is faced with a number of possible options to explore in the *Ethics and Legal Dilemmas* column. However, one topic that appears to appear on a regular basis throughout the literature is that of the ethics of personality assessment. Thus, this is the topic that I have chosen to focus on briefly for this edition's column, as there are a number of points of which it is important to be reminded.

Back in the 1960s the literature highlighted a number of concerns when it came to personality assessment, for example, Messick (1965, p. 136) listed four of the major criticisms regarding testing, including personality assessment:

1. "Tests dictate permanent status and hence undermine self-esteem and limit motivation.
2. Tests decrease diversity of talent by focusing attention on narrowly conceived, easily measureable attainments.
3. The widespread use of tests gives the tester potential control over educational and industrial practices, as well as over the destinies of individuals.
4. Tests foster impersonal and mechanistic evaluations and decisions at the expense of individual freedom of choice."

Fifty years later these concerns still give us something to consider when reflecting on ethical issues in relation to personality assessment. Of course, professional psychology associations work hard to ensure ethical practice in personality assessment, and indeed, the multi-million dollar psychometrics industry also applies standards to encourage good practice when using personality questionnaires. Despite this, Burch and Anderson (2009, p. 748) pointed out that there are often "fraught relations between the *science* of personality research and theory on the one hand, and the *practice* of personality assessment and measurement...on the other". It is perhaps this source of tension that adds further fuel to the ethical issues that arise in personality assessment; that is, *does the left hand know (or even care) about what the right hand is doing?* This is particularly germane when it comes to issues of validity in personality assessment, where the research lends support (or not) to particular assessment tools or methodologies, but practitioners may or may not heed the recommendations coming out of the research, often driven

from their 'weddedness' to particular methodologies or doctrines.

The use of personality assessment is popular, employed across a range of psychology arenas, such as clinical, educational, forensic and organizational settings. There are a wide range of approaches available when assessing personality, such as projective personality assessment (e.g., the Rorschach); however, as highlighted by Boyle and Helmes (2009), self-report questionnaires are the "dominant" personality assessment method. Debates ensue regarding the validity of the different types of assessment, that is, are they psychometrically sound, and do they serve a purpose? This is a critical starting point when considering ethical issues in personality assessment, after all, if the assessment tool does not measure what it purports to measure, then all subsequent decisions that are dependent on that assessment are likely to be spurious. It should be noted at this juncture, that even though they are probably the most popular form of assessment, self-report questionnaires also have their limitations, for example, in psychiatric settings, with young children when there may be concerns about insight, or when the outcomes of assessment may have implications for the assessee (e.g., treatment decisions or employment decisions) where the possibility of distorted responses exists (e.g., impression management/social desirability)(see Boyle & Helmes, 2009).

Thus, the discussion so far highlights the critical need to know and thoroughly understand the tools and methodologies that clinicians use when assessing personality, and the need to continually review their use in an objective light –open to their limitations. However, there is more to it than that, and Segal and Coolidge (2004) have identified a number of recommendations in relation to legal and ethical issues surrounding the objective assessment of personality and psychopathology:

- The most appropriate tool/instrument should be used for the application (*note too: Weiner and Greene's [2008] recommendation that assessors do not use outdated data or results for assessment or when making decisions*).
- A thorough understanding of the purpose (and possible consequences) of the assessment is necessary, as well as an understanding of (and training in) the relevant procedures of assessment to ensure standardization and reduce test biases, and knowledge of the psychometric properties of the specific instrument used.
- Limits of confidentiality should be established and discussed with the person being assessed.
- Appropriate feedback should be given.
- Be aware of the limitations of computer-generated narrative (interpretative) reports, that should be integrated with additional data (e.g., behavioural and/or clinical).
- Only suitably qualified professionals should use the interpretative programs.

- Objective tests should never provide the sole basis for decision-making (e.g., diagnosis).

Additionally, Weiner and Greene (2008, p. 91) remind us to attend to diversity issues in personality assessment, including but not limited to, age, disability, ethnicity, gender, religion and sexual orientation, highlighting “the relevance of a person’s cultural and experiential context to the implications of whatever personality characteristics are identified by the individual’s test responses”.

While the above points will lay a foundation for ethical practice in personality assessment, I will leave the final words with Bricklin (2001, p. 202), who stated that “to ensure [the] continuous sense of an ethical self, psychologists need to have the following:

- Clarity concerning their own personal ethics; beliefs about right and wrong.
- Knowledge of the standards and laws relevant to the practice of psychology.
- Awareness of gut level (intuitive) responses in any situation.
- Responsible decision-making processes available to them when ethical dilemmas arise.
- Knowledge of the limitations of their own competence and willingness to consult when necessary.”

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STUDENT AND TRAINING MATTERS: SPARE A THOUGHT FOR CULTURAL EXPERIENCES IN ASSESSMENT AND DIAGNOSIS OF PERSONALITY DISORDERS

McLytton N. Clever, DPsych
Associate Editor

Personality disorders (PDs) are common with an estimated prevalence of between 10 and 20 percent in the general population (Sadock & Sadock, 2007). Prevalence statistics are mostly available for populations in the Western world, but the same cannot be said about prevalence in the developing countries. Ascoli et al. (2011) reported existence of differences in diagnoses of personality disorders particularly in black ethnic minority groups in the UK. Ascoli and colleagues asserted that Black ethnic minority groups were diagnosed with PDs much less frequently than white people, but the reason of this difference is currently unknown.

This contribution has been motivated by my practice experience as a neophyte clinical psychologist from an ethnic minority background. It is a reflection of my thoughts sitting in multidisciplinary team meetings listening to client assessments being presented. In such presentations my attention is often drawn to discussion of personality disorders and how they are assessed. Of interest to me is the assessment of personality disorders in ethnic minority groups, particularly fitting the categorical criteria to culturally different groups.

What is a personality disorder?

According to the DSM-IV-TR (American Psychiatric Association, 2000), a personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from an individual's culture, is pervasive and inflexible, has an onset in early adolescence or adulthood, is stable overtime, and leads to distress or impairment. This definition was developed in the context of the current dominant views in Western society (Ascoli et al., 2011). However, DSM offers a caveat in regards to diagnosis of PDs in multicultural societies. Rather than relying solely on the categorical approach to applying diagnostic decisions, the DSM encourages a non-mechanical application, that is, one that emphasises deviance as a symptom of dysfunction in the individual.

The DSM also reminds clinicians to take into account the individual's ethnic, cultural, and sociocultural background when making judgments about personality functioning

(American Psychiatric Association, 2000). In addition, it encourages clinicians not to confuse personality disorder with problems associated with acculturation following immigration or with expressions of habits, customs, or religious and political values professed by the individual's culture of origin. To be able to achieve this, clinicians are encouraged to obtain collateral information from informants who are familiar with the person's cultural background. However, clinicians are trained to make diagnostic decisions using the categorical criteria in the DSM, with the cultural aspect taken as an optional extra. Sometimes there is no one to consult!

Categorical diagnostic system

The categorical diagnostic system has been subject of ongoing controversy and debate by researchers and clinicians alike. For example, Jonathon Shedler (see interview published in this edition of ACPARIAN) reminds us that "emotional suffering doesn't come pre-packaged in neatly arranged categories ...". Shedler observes that "categorical diagnosis is especially problematic for personality", and that categorical typology was made to fit personality into a medical disease model, but personality cannot be fitted into a disease model because it is our way of being. A personality disorders specialist, John Livesley, contends that there are two erroneous assumptions about personality disorders in the DSM-IV. First, he argues that the assumption that personality disorders are distinct from each other and from normal personality is wrong. Second, he postulates that the assumption that features of personality disorder are organized into categories is also wrong. Instead, Livesley contends that personality can best be understood on a dimensional level from normal to pathological (Livesley, 2001).

A perspective from social and anthropological theory suggests that applicability of psychiatric diagnostic systems to all cultures is limited, with literature providing arguments in favour of cultural formulation which documents alternative nosologies affecting whole nations and ethnic groups against the current Western-based nosologies (Ascoli et al., 2011). I believe this argument makes clinical sense if the case conferences I have attended and the diagnostic arguments proffered are taken into account. As an example, I sat in a conference where an assessment was presented of an African female who was assessed at the time to be suffering from depression. In addition to the depressive symptoms, the assessor also mentioned existence of some cluster B traits (dependence), which I assume were based on how the client related during the assessment process, and which were subsequently endorsed in Axis II. In subsequent clinical discussions related to this client, the dependence traits became a prominent focus of discussion coupled with clinician's difficulties addressing this. At no time did the clinician, let alone the multidisciplinary team, account for possible cultural influences in this woman's presentation, let alone consider cultural consultation to rule out cultural influences in the presentation.

In Australia, just as in other Western countries, psychological theory and practice are based predominantly on Western cultural values. Professional conceptualisation of personality and psychopathology, in general, tend to favour individualism over interdependence, even though anthropological epistemology suggest that people from Asian, Aboriginal, and/or African cultures, for example, often prize social relationships. One problem for clinicians in the current multicultural climate is that they tend to apply culturally specific criteria (eg., diagnostic criteria in the DSM manual) to people of other cultures, forgetting that some of the criteria are not universally accepted.

It can be argued that the Western diagnostic nosology of personality disorders suits persons nurtured in the Western countries rather than in the developing countries. Morice (1979) notes that a number of qualifying issues need to be considered in the diagnosis of personality disorder when the assessor is from a different culture to the person being assessed. He cautions that:

... there are many people who exhibit atypical (for themselves) behavioural responses to certain environmental stimuli. These behavioural reactions occur in direct response to the stimuli and usually disappear when the stimuli are removed ... A diagnostic dilemma occurs when adverse environmental stimuli are prolonged and behavioural responses may appear to be relatively fixed. (p. 296).

Researchers such as Mezzich and Caracci (2008) observe that a cultural formulation of an illness aims to summarise how the patient's illness is enacted and expressed through these representations of his or her social world. In addition, Mezzich and Caracci postulate that performing a cultural formulation of illness requires the clinician to translate the patient's information about self, social situation, health, and illness into a general biopsychosocial framework that the clinician uses to organise diagnostic assessment and therapeutics. In effect, the clinician seeks to map what he or she has learned about the patient's illness onto the conceptual framework of clinical psychiatry (Mezzich & Caracci, 2008).

Writing on a similar subject, DeMarinis, Ulland & Karlsen (2011) encourage clinicians to consider culture when assessing mental illness. In particular they encourage clinicians to:

- appreciate the variety of cultural expressions and understandings of illness and health conceptions from clients (both minority- but also majority culture variations);
- consider evidence from case analyses that creating a therapeutic space for working with cultural and existential information creates both a safer space for clients, and provides necessary information for the treatment process;

- be culturally aware and use cultural information in diagnosis and treatment planning
- explore their own cultural ways of making meaning as professionals in their different competencies.

Conclusion

Part of what DeMarinis and colleagues put forward has been picked up in the proposed cultural interview in the DSM-V. Despite the good intention of the developers of the DSM manual in encouraging clinicians to incorporate cultural dimension in clinical assessment of mental illness, this intention will remain a pipe dream if cultural studies are not included in current training models in the universities. I can be among the recent graduates to admit that throughout my academic sojourn, I took no class on culture. In hindsight I believe such classes would be very helpful in bridging the requirement for cultural consideration in assessment, diagnosis, treatment planning and execution.

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Call for contributions from student members

The November edition of ACPARIAN will be focusing on Anxiety Disorders. The Editorial Committee is calling on student members who would like to share their experiences working with clients with anxiety, or even sharing their own anxieties seeing clients for the first time, to contribute an article on the topic. Contributions, which should have a clinical focus, should be between 800 - 1000 words in length. Presentation and referencing in-text should adhere to the APA format. Contributions may be edited for clarity and style.

Inaugural
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Prize

Clinical Master's and Doctoral students, currently enrolled in a post graduate Clinical Psychology Professional Program at an Australian university are invited to submit an essay of 2,000 words to compete for the Malcolm Macmillan Prize.

This year the prize of \$1000 will be awarded to the best essay on the topic of "Clinical Psychology & Ethics in the Electronic Age". The essay should be up to 2000 words in length, and be prepared according to the guidelines in the Publication Manual of the American Psychological Association (6th edition; see www.apastyle.com) and submitted as a PDF with a separate cover sheet containing the author's name and affiliations. A masked review procedure will be used on all submitted essays. To prepare essays for masked review, the author's name and affiliations should not appear on the title page or elsewhere in the essay.

Essays should be submitted by 5pm on the 7th September 2012 by email to Bev Eramo at beramo@ozemail.com.au

The winner will be presented with the award at the ACPA AGM which will be held at the ACPA National Conference in Perth in October 2012. The winner will receive a return airfare to the Conference. There will also be two "Highly Commended" certificates for the runners up.

The entrants are required to be student members of ACPA. Information on how to join ACPA is available online

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Submissions to ACPARIAN may include:

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- Articles of particular ethical and/or legal interest to the profession
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- Theoretical perspectives
- Technology updates
- Students' news and viewpoints
- Book reviews
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From time to time, ACPARIAN will focus upon topics or issues of interest and call for submissions accordingly. The ACPA Editorial Board welcomes contributions and suggestions for topics from the membership.

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Submissions should be made electronically, in a Word document, to the editor responsible for that section:

- Students and Training Matters: McLytton Clever
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- Ethics and Legal Matters: Giles Burch
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- Feature articles, Research, and Client Perspectives:
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Please observe the following word limits:

Letters to the Editor: 200 words.

Client Perspectives, Research Articles, Students' Matters and

Ethics and Legal Matters: 750 to 1000 words

Feature articles: 1000 - 1500 words.

References should be in APA style.

Please ensure that submissions are made by the stated deadline. Late submissions may not be accepted.

Authors can expect the Editorial Board to review and change content for clarity and style. The Editorial Board will endeavour to make any significant revisions in consultation with the author. The Editor reserves the right to include or reject written works at any point in the publication process.

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NOVEMBER ISSUE: Anxiety Disorders

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Advertisements are to be presented complete in word, jpeg, and/or format that will allow designer to layout the advert without need for format conversion. No charges will be levied for colour.

Notice to all advertisers

1. Events or activities that will be advertised in the ACPARIAN will be those deemed of relevance to the ACPA membership.
2. All applications and acceptance for advertising submitted to the ACPARIAN shall be subject to the consideration and discretion of the ACPA Editorial Board and the ACPA Board of Directors.
3. Acceptance and publication of an advertisement is not an endorsement by ACPA of the event, activity or product.
4. The topic of the event or activity shall not be similar to any upcoming official ACPA event.
5. ACPA does not take responsibility for any copyright infringements related to the advertisement which is solely the responsibility of the person placing the advertisement.

Australian Clinical Psychology Association

<http://www.acpa.org.au>

For advertising inquiries email McLytton Clever: anocheryl@gmail.com

¹10% discount for ACPA members

Fees may be waived in special circumstances e.g. ACPA events, important public announcements.